

AGENDA OF THE FIFTY-FIFTH SESSION OF THE REGIONAL COMMITTEE

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairman and the Rapporteurs
4. Adoption of the Agenda (document AFR/RC55/1)
5. Appointment of members of the Subcommittee on Credentials
6. The Work of WHO in the African Region 2004: Annual Report of the Regional Director (document AFR/RC55/2)
 - 6.1 Implementation of the Programme Budget 2004-2005
 - 6.2 Progress reports on specific resolutions
 - (a) Elimination of leprosy in the African Region
 - (b) Regional programme for tuberculosis
 - (c) Regional strategy for emergency and humanitarian action
 - (d) Integrated epidemiological surveillance of diseases: Regional strategy for communicable diseases
 - (e) Regional strategy for immunization during the period 2003-2005
 - (f) Health and environment: A strategy for the African Region
 - (g) Poverty and health: A strategy for the African Region
 - (h) Human resources development for health: Accelerating implementation of regional strategy
 - (i) Macroeconomics and health: The way forward in the African Region
 - (j) Food safety and health: A situation analysis and perspectives
 - (k) Scaling up interventions against HIV/AIDS, tuberculosis and malaria in the WHO African Region
 - (l) Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond
 - (m) Roll Back Malaria in the African Region: A framework for implementation
 - (n) Addressing the resurgence of wild poliovirus transmission in the African Region

7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
 - 7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board (document AFR/RC55/3)
 - 7.2 Agendas of the one-hundred-and-seventeenth session of the Executive Board, the Fifty-ninth World Health Assembly and the fifty-sixth session of the Regional Committee (document AFR/RC55/4)
 - 7.3 Method of work and duration of the World Health Assembly (document AFR/RC55/5)

8. Report of the Programme Subcommittee (document AFR/RC55/6)
 - 8.1 WHO Programme Budget 2006-2007: Orientations for implementation in the African Region (document AFR/RC55/7)
 - 8.2 Country cooperation strategies: Implementation, lessons learnt and the way forward in the African Region (document AFR/RC55/8)
 - 8.3 Achieving health Millennium Development Goals: Situation analysis and perspectives in the African Region (document AFR/RC55/9)
 - 8.4 Local production of essential medicines, including antiretrovirals: Issues, challenges and perspectives in the African Region (document AFR/RC55/10)
 - 8.5 Control of human African trypanosomiasis: A strategy for the African Region (document AFR/RC55/11)
 - 8.6 Cardiovascular diseases in the African Region: Current situation and perspectives (document AFR/RC55/12)
 - 8.7 Implementation of the Framework Convention on Tobacco Control in the African Region: Current status and the way forward (document AFR/RC55/13)
 - 8.8 Reproductive cloning of human beings: Current situation (document AFR/RC55/14)
 - 8.9 Guiding principles for strategic resource allocations (document AFR/RC55/15)

9. General Programme of Work 2006-2015 (document AFR/RC55/16)

10. Information
 - 10.1 Report on human resources in the WHO African Region (document AFR/RC55/INF.DOC/1)
 - 10.2 International migration of health personnel: A challenge for health systems in developing countries (document AFR/RC55/INF.DOC/2)

- 10.3 Tuberculosis control: The situation in the African Region (document AFR/RC55/INF.DOC/3)
 - 10.4 Sickle-cell disease: A public health problem in the African Region (document AFR/RC55/INF.DOC/4)
 - 10.5 Avian influenza: Spread and pandemic preparedness and response in the African Region (document AFR/RC55/INF.DOC/5)
 - 10.6 Smallpox: Destruction of variola virus stocks (document AFR/RC55/INF.DOC/6)
 - 10.7 Important health-related events in the Region
11. Round Table: Prevention of HIV/AIDS in the African Region (document AFR/RC55/RT/1)
 12. Panel Discussion: Social determinants of health and health inequalities: A matter of concern in the African Region (document AFR/RC55/PD/1)
 13. Special session on health financing
 14. Dates and places of the fifty-sixth and fifty-seventh sessions of the Regional Committee (document AFR/RC55/17)
 15. Procedural decisions (document AFR/RC55/18)
 16. Adoption of the report of the Regional Committee (document AFR/RC55/20)
 17. Closure of the fifty-fifth session of the Regional Committee.

ANNEX 3

PROGRAMME OF WORK

DAY 1: Monday, 22 August 2005

10.00 a.m. - 12.00 noon.	Agenda item 1	Official opening ceremony
	Agenda item 2	Constitution of the Subcommittee on Nominations
12.00 noon - 2.00 p.m.	<i>Lunch Break</i>	
2.00 p.m. - 2.05 p.m.	Opening remarks	by the Chairman of the fifty-fourth session of the Regional Committee
2.05 p.m. - 2.15 p.m.	Agenda item 2	Report of the Subcommittee on Nominations
2.15 p.m. - 2.30 p.m.	Agenda item 3	Election of the Chairman, Vice-Chairmen and the Rapporteurs
	Agenda item 4	Adoption of the Agenda (document AFR/RC55/1)
	Agenda item 5	Appointment of members of the Subcommittee on Credentials
2.30 p.m. - 3.30 p.m.	Agenda item 6	The Work of WHO in the African Region 2004: Annual Report of the Regional Director (document AFR/RC55/2)
		Remarks by the Director-General of WHO
4.00 p.m. - 4.30 p.m.	<i>Break: Tea and Fruits</i>	
4.30 p.m. - 5.20 p.m.	Agenda item 6 (cont'd)	
6.30 p.m.	<i>Reception offered by the Director-General and the Regional Director for Africa</i>	

DAY 2: Tuesday, 23 August 2005

8.30 a.m. - 10.00 a.m.	Agenda item 7	Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
	Agenda item 7.1	Ways and means of implementing resolutions of regional interest adopted by the Executive Board (document AFR/RC55/3)
	Agenda item 7.2	Agendas of the one-hundred-and-seventeenth session of the Executive Board, the Fifty-ninth World Health Assembly and the fifty-sixth session of the Regional Committee (document AFR/RC55/4)
	Agenda item 7.3	Method of work and duration of the World Health Assembly (document AFR/RC55/5)
10.00 a.m. - 10.30 a.m.	<i>Break: Tea and Fruits</i>	
10.30 a.m. - 12.30 p.m.	Agenda item 8	Report of the Programme Subcommittee (document AFR/RC55/6)
	Agenda item 8.1	WHO Programme Budget 2006-2007: Orientations for implementation in the African Region (document AFR/RC55/7)
12.30 p.m. - 2.30 p.m.	<i>Lunch Break</i>	
2.30 p.m. - 4.00 p.m.	Agenda item 8.2	Country cooperation strategies: Implementation, lessons learnt and the way forward in the African Region (document AFR/RC55/8)
4.00 p.m. - 4.30 p.m.	<i>Break: Tea and Fruits</i>	
4.30 p.m. - 6.00 p.m.	Agenda item 11	Round Table Prevention of HIV/AIDS in the African Region (document AFR/RC55/RT/1)

DAY 3: Wednesday, 24 August 2005

8.30 a.m. - 10.00 a.m. **Agenda item 8.3** Achieving the health Millennium Development Goals: Situation analysis and perspectives in the African Region (document AFR/RC55/9)

10.00 a.m. - 10.30 a.m. *Break: Tea and Fruits*

10.30 a.m. - 12.30 p.m. **Agenda item 8.4** Local production of essential medicines, including antiretrovirals: Issues, challenges and perspectives in the African Region (document AFR/RC55/10)

12.30 p.m. - 2.00 p.m. *Lunch Break*

2.00 p.m. - 3.30 p.m. **Agenda item 8.5** Control of human African trypanosomiasis: A strategy for the African Region (document AFR/RC55/11)

3.30 p.m. - 4.00 p.m. *Break: Tea and Fruits*

4.00 p.m. - 5.30 p.m. **Agenda item 8.6** Cardiovascular diseases in the African Region: Current situation and perspectives (document AFR/RC55/12)

DAY 4: Thursday, 25 August 2005

8.30 a.m. - 9.30 a.m. **Agenda item 8.7** Implementation of the Framework Convention on Tobacco Control in the African Region: Current status and the way forward (document AFR/RC55/13)

9.30 a.m. - 10.30 a.m. **Agenda item 8.8** Reproductive cloning of human beings: Current situation (document AFR/RC55/14)

10.30 a.m. - 11.00 a.m. *Break: Tea and Fruits*

11.00 a.m. - 12.00 noon. **Agenda item 8.9** Guiding principles for strategic resource allocations (document AFR/RC55/15)

- 12 noon – 12.15 p.m. HIV prevention in the African Region: A call for accelerated action
- 12.15 p.m. – 12.30 p.m. Global Ministerial Summit on Health Research, 2008
- 12.30 p.m. - 2.00 p.m. *Lunch Break*
- 2.00 p.m. – 3.00 p.m. **Agenda item 9** General Programme of Work 2006-2015
(document AFR/RC55/16)
- 3.00 p.m. – 4.00 p.m. **Agenda item 10** Information
- Agenda item 10.1** Report on human resources in the WHO African Region (document AFR/RC55/INF.DOC/1)
- Agenda item 10.2** International migration of health personnel: A challenge for health systems in developing countries (document AFR/RC55/INF.DOC/2)
- Agenda item 10.3** Tuberculosis control: The situation in the African Region (document AFR/RC55/INF.DOC/3)
- Agenda item 10.4** Sickle-cell disease: A public health problem in the African Region (document AFR/RC55/INF.DOC/4)
- Agenda item 10.5** Avian influenza: Spread and pandemic preparedness and response in the African Region (document AFR/RC55/INF.DOC/5)
- Agenda item 10.6** Smallpox: Destruction of variola virus stocks (document AFR/RC55/INF.DOC/6)
- Agenda item 10.7** Important health-related events in the Region
- 4.00 p.m. - 4.30 p.m. *Break: Tea and Fruits*
- 4.30 p.m. - 6.30 p.m. **Agenda item 12 Panel Discussion**
Social determinants of health and health inequalities: A matter of concern in the African Region (document AFR/RC55/PD/1)

DAY 5: Friday, 26 August 2005

9.00 a.m. - 10.30 a.m. **Special session:** Sustainable health financing in Africa

10.30 a.m. – 11.00 a.m. *Break: Tea and Fruits*

11.00 a.m. - 12.30 p.m. **Special Session** (cont'd)

12.30 p.m. – 2.00 p.m. *Lunch Break*

2.00 p.m. - 4.00 p.m. **(Final agenda items 13, 14, 15, 16)**

Agenda item 13 Dates and places of the fifty-sixth and fifty-seventh sessions of the Regional Committee (document AFR/RC55/17)

Agenda item 14 Procedural decisions (document AFR/RC55/18)

Agenda item 15 Adoption of the report of the Regional Committee (document AFR/RC55/20)

Agenda item 16 Closure of the fifty-fifth session of the Regional Committee.

REPORT OF THE PROGRAMME SUBCOMMITTEE**OPENING OF THE MEETING**

1. The Programme Subcommittee met in Brazzaville, Republic of Congo, from 14 to 17 June 2005.
2. The list of participants is attached as Appendix 1.
3. The Regional Director, Dr Luis G. Sambo, welcomed the members of the Programme Subcommittee (PSC), members of the Executive Board from the African Region and the Chairman of the African Advisory Committee for Health Research and Development.
4. He underscored the fact that this Subcommittee is taking place within the context of transition as it is the first Programme Subcommittee meeting since his election as Regional Director. There is also the transition from the Tenth to Eleventh General Programme of Work, and there are new opportunities to address the health challenges in the continent. Challenges such as the double burden of communicable and noncommunicable diseases, and the unacceptable level of maternal and infant mortality associated with weak health systems require immediate, effective and focused responses.
5. Recalling the expansion of the terms of reference of the Programme Subcommittee in 1977 during the twenty-seventh session of the Regional Committee, he reiterated the mandate of the PSC. This includes, among other things, analysing and reviewing Programme Budgets to ensure that they are consistent with the decisions and recommendations of the Governing Bodies and that they reflect the health priorities in the African Region, as well as advising the Regional Committee on all relevant issues submitted to the ministers of health for review and decision. He specifically called upon the members of the PSC to advise the Regional Director on any issue of concern between sessions since their role is similar to that of the Executive Board vis-à-vis the World Health Assembly.
6. The Regional Director called on members of the PSC to undertake an in-depth analysis of all the documents on the agenda, to make high quality contributions and to come up with relevant and realistic recommendations to enrich the documents and facilitate further deliberations of the ministers of health at the Regional Committee.

7. In conclusion and in the light of the PSC mandate, he urged the members to thoroughly reflect on the current HIV/AIDS situation and the need to reinvigorate prevention activities in the African Region.

8. The Director of Programme Management, Dr Paul Lusamba-Dikassa, proposed the members of the bureau to the PSC for consideration. The bureau was constituted as follows:

Chairman:	Professor Mohammed Lemine Ba (Mauritania)
Vice-Chairman:	Dr Shehu Sule (Nigeria)
Rapporteurs:	Dr Boureima Hama Sambo (Niger)
	Dr Habib Saizi Somanje (Malawi)
	Dr Alexandre Manguéle (Mozambique).

9. Professor Mohammed Lemine Ba, Chairman of the Programme Subcommittee, thanked the members for the confidence placed in him. He congratulated the Regional Director and his team for their new mandate. He reminded the meeting of the major and numerous health challenges and the need to work together to fight disease in the Region. While underlining the high quality and timeliness of the documents, he assured the Secretariat that they would be enriched by PSC contributions. He further stated that the agenda of the fifty-fifth session of the Regional Committee addresses important health matters in the Region. He concluded by commending the Secretariat for the good quality of the organization of the meeting.

10. The Chairman called for consideration of the agenda (Appendix 2) and the programme of work (Appendix 3) which were adopted without amendments.

WHO PROGRAMME BUDGET 2006-2007: ORIENTATIONS FOR IMPLEMENTATION IN THE AFRICAN REGION (document AFR/RC55/PSC/3)

11. Dr Paul Lusamba-Dikassa of the Secretariat presented an overview of the Programme Budget 2006–2007.

12. This budget, which is the first to be prepared under the Eleventh General Programme of Work, takes into account the priorities identified in the CCS documents and global priorities defined by the Director-General of WHO. These priorities are reflected in the 15 priority areas of work identified by the Regional Director. The Programme Budget 2006–2007 approved by the World Health Assembly in May 2005 is a results-based integrated budget stemming from a participatory and iterative planning process.

13. For the 2006–2007 period, the budget of the African Region increases by US\$ 204.7 million made up of 6% from the Regular budget and 94% from Voluntary funds. Thus, the

total budget amounts to US\$ 949.5 million, comprising 21.4% from the Regular budget and 78.6% from Voluntary funds. The African Region receives the highest budgetary allocation after headquarters. Out of the approved amount, US\$ 784.4 million was allocated to regional priorities. Furthermore, US\$ 716.6 million (75%) has been earmarked for expenditure in countries and US\$ 232.9 million (25%) for Regional Office expenditure, including intercountry allocations.

14. The execution of the budget will be guided by four major guiding principles, namely: decentralization of resources to countries; integration of interventions; strengthening WHO core presence in countries; and strengthening monitoring and evaluation for greater efficiency and accountability.

15. Member countries are being urged to collaborate in the formulation of workplans based on the CCS documents, choose a limited number of areas of work and allocate at least 15% of the national budget to the health sector. On its part, WHO should define procedures for delegating powers to the WHO country representatives and divisional directors; re-profile the WHO country office staff; approve work programmes in November 2005; and improve the quality of implementing, monitoring and evaluating the Programme Budget.

16. Members of the Subcommittee expressed their satisfaction with the quality of the document and the general increase in the budget allocation to the African Region.

17. In the discussions that ensued a number of general comments were made. There is need to provide an indication of the average percentage of the Voluntary funds that are actually received for programme implementation. Given that health development partners at the country level are increasingly moving away from project funding to either Budget support or sector-wide approaches (SWAps), there is need to clarify whether WHO would be prepared to participate in those approaches for supporting countries. Given the increase in the number of health development partners and funding at the country level, there is need for WHO to support ministries of health to strengthen their leadership, coordination and advocacy. There is need to harmonize the budget cycles across the United Nations agencies.

18. It was suggested to intensify advocacy by WHO and ministries of health for the implementation and monitoring of the Heads of State commitment in Abuja to allocate 15% of the national budget to health. In this regard, the Organization should continue providing support to countries in undertaking and institutionalizing the national health accounts. WHO should also advocate for countries to allocate more resources to health, especially those arising from highly-indebted poor country (HIPC) initiative funds. Concern was also expressed regarding the allocation of funds to countries, and subsequent variations in the allocations with regard to some areas of work.

19. The Subcommittee welcomed the ongoing re-profiling of WHO country offices since it will strengthen their technical support to countries. It also emphasized that social health insurance is one of the potential sources of sustainable financing for health.

20. The Subcommittee proposed the following specific amendments to the document:

- (a) Under the Budgetary Analysis section, the Subcommittee sought clarification regarding the: (i) 3% of the global regular budget being withheld by the Director-General against the possibility that there may be some non-payments of assessments by Member States and sought clarification on how those funds could be made available to countries, in the event that all Member States pay their assessed contributions; and (ii) the mechanism that WHO would use to protect countries against the negative effects of fluctuations in exchange rates;
- (b) Under the Guiding Principles for Implementation, in paragraph 33, further clarification was sought for proposed decentralization in terms of delegation of authority and responsibility to WHO representatives and division directors;
- (c) In paragraph 35, there is need to emphasize: (i) the necessity for strong collaboration between UN agencies for planning, implementation, monitoring and evaluation; (ii) the integration of programmes within one Ministry of Health and one health system to avoid vertical implementation of programmes that undermine the effectiveness of national health systems;
- (d) In paragraph 41, it was recommended that the Regional Director establish a contingency fund of US\$ 6.1 million, representing 3% of the Regular budget, to provide for unplanned activities, with any unused balance being reallocated to countries during the second half of the second year of the biennium;
- (e) In paragraph 42, it was recommended that WHO should also play an active advocacy role in encouraging countries to provide at least 15% of their national budgets for health;
- (f) In Annex 3, the Subcommittee welcomed the inclusion of the Surveillance, prevention and management of chronic, noncommunicable diseases area of work among the regional priorities but expressed concern regarding the meagre amount of resources allocated to this area of work.

21. The Secretariat thanked the members for their valuable comments and assured them that they would be incorporated in the final report. It was explained that the Programme Budget 2006–2007 was approved by the World Health Assembly and the Subcommittee is requested to provide orientations to facilitate implementation. It is understood that there is a certain degree of uncertainty regarding the amounts and timing of the Voluntary funds component of the Budget, but it was stated that given past experience, the majority of funds

anticipated are actually received. The Organization is working on the basis of an integrated budget and is negotiating with donors to provide unearmarked funds.

22. Clarification was provided on the allocation to countries and to the Regional Office as reflected in Annex 6 and Annex 7, respectively. In this regard, it was pointed out that most of the funds under Intercountry Programme (ICP) will be used in providing support to countries, and a new table will be provided.

23. The Secretariat concurred that as the Surveillance, prevention and management of chronic Noncommunicable diseases area of work is a regional priority, there is a need to continue advocating for increased resource allocation.

24. Regarding decentralization, it was explained that the Regional Office is working on a mechanism for simplifying and facilitating the process of implementation of approved workplans. Concerning the issue of exchange rate fluctuations, the Subcommittee was informed that the Regional Office and Headquarters were considering different ways of minimizing risks, including putting some currencies under the WHO hedging mechanisms.

25. Within countries, WHO works at strategic level and therefore agrees with sector-wide approaches (SWAps) and is working with other partners in countries in the context of the United Nations Development Assistance Framework. However, WHO financial rules and procedures do not allow full participation in the Budget support approach, since by its nature WHO is a technical cooperation agency rather than a funding agency.

26. The Subcommittee approved the document with amendments and prepared a draft resolution on the subject to be submitted to the Regional Committee for review and adoption.

COUNTRY COOPERATION STRATEGIES: IMPLEMENTATION, LESSONS LEARNT AND THE WAY FORWARD IN THE AFRICAN REGION (document AFR/RC55/PSC/4)

27. The document on country cooperation strategies was presented by Dr Paul Lusamba-Dikassa of the Secretariat. It contains a background and discusses implementation, lessons learnt, the way forward, monitoring, evaluation and conclusion.

28. This document gives a progress report on the orientation given at the fifty-first session of the Regional Committee to develop country cooperation strategies (CCSs) in all 46 Member countries. It also provides an indication of how the process has evolved, lessons learnt and the way forward for maximizing the gains of the CCS process.

29. The increasing complexity of the health sector, dwindling resources in Africa, international commitment to achieving the Millennium Development Goals by 2015, and the growing number of actors in the health sector with various agendas have led to an intensive search for better coordination mechanisms at country level.

30. The Country Focus Policy, introduced in 2001 as part of the WHO Reform, intends to place the priority health needs of Member States at the centre of WHO work while enhancing the effectiveness, responsiveness and coherence of WHO presence at country level. The Country Cooperation Strategy, a core component of the WHO Country Focus Policy, is a country-specific, adaptable, medium-term (4–6 years) framework for cooperation between WHO and the individual countries. The CCS defines a strategic agenda for WHO work in each country and discusses the implications of this agenda for the whole Organization.

31. The formulation of CCSs in 45 of the 46 Member countries enabled WHO to undertake extensive consultations at country level with ministries of health as well as their national, bilateral and multilateral partners in order to determine the main health and development priorities for country-level planning. The analysis of the 45 CCS documents helped to define the regional priority programmes for technical cooperation. The Regional Office commenced a process of improving technical and managerial capacities of WHO country offices.

32. The key lessons learnt during the CCS formulation exercise include the need for WHO technical support to be more responsive, focused, coordinated and strategic. This will require a change in the way country teams function, and continuous advocacy will be required to obtain overall acceptance of anticipated changes. The real challenge is to translate the strategic agendas into sustainable actions for better health outcomes.

33. In order to advance the CCS agenda within the African Region, Member States and partners should consider the CCS as a viable planning tool and the basis for developing biennial programme budgets. WHO should ensure that the CCSs are actually put into practice at all levels and that the strategic agendas are implemented. In addition, WHO should fully integrate the CCS into its managerial processes and ensure that well-led, well-staffed and well-equipped country teams are in place to effectively coordinate and deliver the WHO technical support.

34. Members of the Subcommittee expressed their satisfaction with the quality, relevance and pertinence of the document.

35. The following were some of the specific amendments to the document proposed by the Subcommittee:

- (a) In the Background section, paragraph 4 on objectives, to be responsive to the needs of countries, there is need for WHO to clearly define the location of WHO staff within countries; and consider the possibility of placing some of them within ministries of health;
- (b) In the Implementation section, paragraph 14, many delegates emphasized the stewardship role of ministries of health in country-level coordination of health interventions and actors; all partners' programmes should be aligned with national health plans; coordination across the different levels of WHO is needed during planning, implementation and evaluation of activities;
- (c) In paragraph 21, there is need to better reflect the objective of strengthening WHO technical leadership at country level; for (c) it was recommended that capacities be strengthened within ministries of health and country offices; in (e), the concept of one country strategy, plan and budget is necessary, considering that various partners operating at country level have different programming cycles and plans;
- (d) In the Challenges section, paragraph 22, it was suggested that WHO at Regional Office and HQ levels should have effective resource decentralization which contributes to the empowerment of WHO representatives to effectively implement the Programme Budget; more attention should be given to small island developing states due to their vulnerability to NCDs and HIV/AIDS; in (h) the paragraph needs to take into account SWAPs, National Health Plans, PRSPs etc;
- (e) In the section on Lessons Learnt, paragraph 28, the last sentence should be more explicit on striking a balance between routine implementation and strategic functions and support;
- (f) In The Way Forward, paragraph 34(c) there is need to clarify the first sentence related to one country strategy, plan and budget;
- (g) In the Conclusion, there is need to state that efforts to strengthen country offices should not weaken the ministries of health.

36. In response to issues raised, the Secretariat thanked the members for their valuable comments and assured them that they would be incorporated in the final document. However, clarifications were given on the intention of the document to encourage Member States to reflect about ways in which WHO can better respond to the needs of countries while respecting the political and stewardship role of governments and the mandate of other cooperating agencies.

37. In relation to re-profiling the country offices, the exercise should be undertaken on the basis of the CCS and country priorities in consultation with ministries of health, including the location of WHO staff. It was explained that the one country strategy, plan and budget was a way of harmonizing the support given to countries by the three levels of the Organization. Ministries of health will still coordinate the formulation of national health plans that should inform the WHO biennial plan. Through WHO normative functions, the ministries of health will be strengthened to fulfill their coordination role, including SWAps.

38. It was recommended that the strengthening of WHO country offices and re-profiling exercise should not result in weakening of the ministries of health but rather enhance complementarity and better technical support to countries. It was explained that re-profiling aims to improve WHO country team competences in order to better respond to country needs.

39. The Subcommittee approved the document with amendments and prepared it for submission to the Regional Committee for review and adoption.

ACHIEVING HEALTH MILLENNIUM DEVELOPMENT GOALS: SITUATION ANALYSIS AND PERSPECTIVES IN THE AFRICAN REGION

(document AFR/RC55/PSC/5)

40. Dr Chris Mwikisa of the Secretariat presented an overview of the document on achieving the health Millennium Development Goals (MDGs) in the African Region.

41. The introduction describes the MDGs as adopted by the Millennium Summit in 2000. The eight goals provide a framework for measuring development progress; they are also linked to the primary health care approach and health-for-all initiatives. Three of the MDGs are health goals and the rest are closely related to health.

42. The situation analysis noted that although some achievements have been made in some countries on some MDGs, overall progress remains slow mainly due to weak health systems and inadequate resources.

43. Child mortality is not decreasing rapidly enough, averaging 174 deaths per 1000 live births compared to 186 in 1990. Maternal mortality has worsened from 870 per 100 000 live births to an estimated 1000 per 100 000 between 1990 and 2003. Combating HIV/AIDS, tuberculosis and malaria is also slow.

44. The perspectives section pointed out opportunities such as the growing recognition of the health sector as central to development. It also noted the challenges of inadequate

resources and weak health systems. Proposed actions include health systems development, scaling up interventions and resource mobilization, among others. Monitoring and evaluation should be undertaken using the indicators as already provided under each MDG.

45. The national authorities have the primary responsibility to achieve the MDGs, to monitor and to report on their progress. Development partners, including WHO, should provide technical and financial support.

46. Members of the Subcommittee commended the Secretariat for the quality of the presentation and contents of the document. They appreciated the linkage between the MDGs and earlier initiatives such as primary health care, health-for-all and the New Partnership for Africa's Development. They requested an assessment of the shortcomings and level of implementation of these initiatives in order to build on the positive experiences. Members emphasized that governments needed to do more to overcome the challenges and gaps in order to achieve the MDGs, especially addressing the critical role of human resources at all levels. Interventions for accelerating the achievement of MDGs should be integrated into ongoing health reforms and other national development processes.

47. With regard to resource mobilization for MDGs, clarification was sought on the follow-up activities after the high-level forum that was held in Abuja in 2004.

48. The Subcommittee then proposed specific amendments as follows:

- (a) In the Executive Summary, paragraph 4, second sentence, replace the word "can" with "are urged to";
- (b) In the Situation Analysis section, paragraph 5, update the data to 2003;
- (c) In paragraph 9, WHO should take part in national committees on vitamin A supplementation and fortification of food with micronutrients;
- (d) In paragraph 10, emphasize the fact that more than 60% of deliveries occur at home; reasons for this should be given in the document;
- (e) In paragraph 13, the coverage and effectiveness of indoor residual spraying should also be included; the number of countries implementing combination therapy needs to be updated, and the Region should ensure that these drugs are accessible and affordable;
- (f) In paragraph 17, the need to have motivated human resources to tackle the challenges was raised;
- (g) In the Perspectives section, paragraph 21, add "new and re-emerging diseases";
- (h) In paragraph 22, reformulate the second sentence to show that poverty will be reduced by fighting diseases;

- (i) In paragraph 23, clarify the phrase “pro-poor national development initiatives”;
- (j) In paragraph 29, remove HIPC as it is not an augmentation of national resources; make a separate argument for linking HIPC to the recently granted debt relief and channelling this money to health;
- (k) In paragraph 30, add language from page 4 paragraph 3 of Resolution WHA58.30 regarding the percentage of GNP;
- (l) In the Monitoring and Evaluation section, paragraph 31, add process indicators which will be more meaningful to districts and communities to monitor progress in maternal and infant mortality reduction, including the issue of documenting stillbirths;
- (m) In Roles and Responsibilities, paragraph 32, explain what mechanisms WHO has to ensure that countries receiving debt relief actually use it for health;
- (n) In paragraph 33, move financial monitoring issues back to paragraph 31; recast the end of the last sentence and add that governments should strengthen their health information systems, research capacities and community-based surveys in order to provide up-to-date information;
- (o) In paragraph 35, clarify the meaning of the first and second sentences.

49. The Secretariat made the following clarifications to the issues raised. Figures in the document would be updated as suggested by the members, and countries would be supported to estimate the costs and identify specific financial gaps for achieving the MDGs. WHO would assist ministries of health to improve their capacities for negotiating for increased resources for health and would also improve the efficiency of delivering technical assistance to countries through an integrated package of support. It was explained that costed basic health-care packages need to be incorporated into the interventions towards the achievement of health-related MDGs.

50. The importance of sufficient human resources was acknowledged, and the participants were informed that WHO will be creating a human resources for health observatory. Concerning maternal mortality, the Secretariat reiterated that the most reliable indicator was “the percentage of deliveries attended by skilled attendants”; however, WHO was going further to look at the environment of the deliveries. Stillbirths are not recorded, and hence the best way to track them is to use community-based interventions linked to Integrated Management of Childhood Illness (IMCI) and newborn care.

51. The Secretariat informed the PSC members that WHO would continue its advocacy role with governments and Bretton Woods institutions as well as bilateral and multilateral partners to ensure that funds released from debt relief would be used for health.

52. The Secretariat thanked the members for their valuable comments and assured them that their changes would be incorporated in the final document.

53. The Subcommittee approved the document with amendments and urged the Secretariat to prepare a region-specific draft resolution on the subject to be submitted to the Regional Committee for review and adoption.

LOCAL PRODUCTION OF ESSENTIAL MEDICINES, INCLUDING ANTIRETROVIRALS: ISSUES, CHALLENGES AND PERSPECTIVES IN THE AFRICAN REGION (document AFR/RC55/PSC/6)

54. Dr Alimata J. Diarra-Nama of the Secretariat introduced the document on essential medicines.

55. The document consists of an introduction and situation analysis, issues, challenges, perspectives, roles and responsibilities, and conclusion.

56. The world production of medicines is concentrated in a few industrialized countries. Production of generic medicines has become an important economic activity and contributes to improving access to medicines. Pharmaceuticals production takes place at three levels: primary, secondary and tertiary.

57. There are a number of issues related to access to medicines, namely, inadequate health-care budgets and high expenditure (as much as 30%) on pharmaceuticals. High medicine prices coupled with inadequate financing restrict poor people from accessing medicines. There is a great need for affordable generics and for balancing industrial and public health perspectives. The production of patented essential medicines is limited.

58. The challenges to production of generic medicines in the Region include limited capacity of countries to effectively make use of the TRIPS safeguards; non-conducive social, political and economic environments; weak infrastructure, economic and industrial development as well as high cost of utilities; weak enforcement of policies and legislation.

59. The future prospects for countries in the Region lie in the development and implementation of appropriate enabling government policies; enhancement of South-South collaboration and technology transfer; and exploration of the options of parallel importation, compulsory licensing and importation of generic equivalents.

60. Members of the Subcommittee described the document as relevant and pertinent. Discussions followed, and a number of general comments were made.

61. While considering the local production of essential medicines, it is important to take into account the policy environment of liberalization and privatization that countries are operating in. It is important to take into account that the contemporary role of the government is that of policy development, facilitation and regulation, and creation of an enabling environment for the growth of the private sector. In this regard, the role of ministries of health (with WHO support) is to strengthen pharmaceutical regulatory mechanisms and relevant expertise.

62. It is necessary to highlight that the current inaccessibility of antiretroviral medicines is partly due to dependence on importation and that there is need for research into local production. It is vital to underscore the importance of bulk-purchasing of essential medicines, through regional economic communities to exploit economies of scale, and hence obtain medicines at competitive prices. There is a need to create a viable market for essential medicines, to develop regional quality assurance facilities to curb importation of medicines of substandard quality, and to document and share best practices in the production of medicines. WHO should support countries to strengthen their capacities in terms of legislation and regulation of pharmaceutical production.

63. The following were some of the specific amendments to the document proposed by the Subcommittee:

- (a) The Situation Analysis should include a review of the extent of (i) implementation of resolutions AFR/RC38/R19 and AFR/RC49/R5 which are related to increasing access to essential medicines; (ii) production of essential medicines, including traditional medicines; there is need to mention the necessity for production and retention of the necessary human resource capacities for the pharmaceutical sector to ensure research and development of medicines;
- (b) In paragraph 9, the second sentence should note that eight countries have no industry, and Sao Tome and Principe should be added to footnote 9;
- (c) In paragraphs 10 to 13, the names of the countries should be specified;
- (d) In paragraph 14, the issue of lack of access to antiretroviral medicines should be stated upfront and underscored;
- (e) In the Portuguese version, paragraph 16, replace the word "inadequate" with "low";
- (f) In the French version, paragraph 17, replace "considerations" with "domaines";
- (g) In paragraph 22, add issues related to quality control and marketing of pharmaceuticals;
- (h) Reformulate the section on challenges along the lines of the document on Millennium Development Goals (AFR/RC55/PSC/5);

- (i) Under Perspectives, paragraph 27, add the following: (i) “establish a pharmaceutical regulatory facility at the regional level to take care of, among others, quality control issues and building dialogue on related matters among countries”; (ii) “promote local pharmaceutical production at subregional and regional levels to ensure sustainability”;
- (j) Under Roles and Responsibilities, countries should be encouraged to join regional economic communities instead of developing individual production; the following recommendations of the joint WHO-AU-UNDP workshop on TRIPS and access to medicines, which was held in Addis Ababa in March 2005, should be incorporated: encourage south-south collaboration, identify centres of excellence for regional or subregional production, foster public and private partnerships, undertake feasibility studies with a focus on quality and accessibility;
- (k) In paragraph 33(a), the second line should read: “transfer, and facilitate the development of local production capacity for essential medicines”; in (b) refer to the SADC experience with harmonization of medicine regulation; in (d), include pharmaceutical research and development, especially using locally available herbs and other raw materials; in (e), add compulsory licensing.

64. The Secretariat thanked the members for their valuable input and assured them that their comments would be incorporated in the final document. It was explained that this topic was recommended for inclusion in the agenda of the fifty-fifth session of the Regional Committee at the fifty-fourth session. The role of WHO is to work closely with ministries of health and other concerned ministries (e.g. trade and industry) and development partners (e.g. United Nations Industrial Development Organization, World Trade Organization). The Secretariat welcomed suggestions for the identification and sharing of information on Good Manufacturing Practices and good practices in medicine regulation. The meeting was informed that there are three regional medicine quality control laboratories that are at the disposal of Member States. The role of the African Union and regional economic communities in local production was recognized as well as the advantages of bulk purchasing.

65. The Subcommittee approved the document with amendments and prepared to submit it to the Regional Committee for review and adoption.

CONTROL OF HUMAN AFRICAN TRYPANOSOMIASIS: STRATEGY FOR THE AFRICAN REGION (document AFR/RC55/PSC/7)

66. Dr James N. Mwanzia of the Secretariat introduced the document on human African trypanosomiasis (HAT).

67. The distribution of human African trypanosomiasis, also known as “sleeping sickness”, is limited to the African continent. About 60 million people are at risk of the disease which is completely fatal if untreated. Therefore, HAT is a major public health problem in the Region, with the ongoing resurgence of both human and animal trypanosomiasis due to lack of sustained surveillance activities.

68. The strategy aims to control epidemics in the medium term and to eliminate the disease as a public health problem in the long term. The specific objectives of the strategy are: (i) to strengthen the capacities of all affected countries to plan, implement, monitor and evaluate national HAT control programmes; (ii) to promote the involvement of public and private sectors in HAT control; and (iii) to promote operational research as a tool to identify and address issues arising from the implementation of national HAT control programmes.

69. If the proposed strategy is adopted by the Regional Committee and implemented in the affected countries, it will contribute to the reduction of HAT morbidity and mortality in the Region and hence to the elimination of the disease as a public health problem by 2015.

70. Members of the Programme Subcommittee expressed the opinion that the proposed strategy is pertinent and well-written. It addresses an important issue faced by many communities in rural areas of Africa.

71. The members welcomed the document for its relevance and congratulated the Secretariat on its quality. They also commended its focus on operational research and called attention to the need to also include health system research and to add data on mortality in the situation analysis.

72. Members of the Subcommittee suggested the following specific amendments for improving the document:

- (a) In paragraph 15, to add a specific objective on the need for baseline data on prevalence, incidence and mortality of HAT to facilitate the planning process;
- (b) The five research institutes involved in sleeping sickness activities should be included in the document, and WHO should support the strengthening of their capacity and encourage inter-institutional collaboration;
- (c) The first sentence in paragraph 21 should read: “Communities should contribute to sustainability and minimizing costs”;
- (d) In paragraph 24, add activities on health education in schools starting at primary school level;

- (e) Concern was raised about how realistic the proposed targets are in terms of available resources and timeframe;
- (f) In paragraph 33, add a sentence to address the need for assessment before development of national policies, especially in those countries where the endemicity level is not known. A question was raised as to whether there is inter-ministerial collaboration on the issue of animal trypanosomiasis control and collaboration between other vector-borne disease control programmes. The Subcommittee members emphasized the need to have a balance between some level of verticalization and integration of HAT control into disease control programmes;
- (g) In the Executive Summary, paragraph 2, the second sentence should read: "Unfortunately, due to lack of regular surveillance activities and reduced resource allocation to HAT as well as changing health priorities and non-availability of drugs, the disease has been neglected." The third sentence can be deleted.

73. The Secretariat thanked the Subcommittee members and assured them that their valuable comments would be incorporated in the final document. Clarifications were provided on the fact that: (a) HAT control activities are integrated at operational level while the HAT programme manager is required at the central level for programme management and accountability; (b) vector control is especially necessary in *T. rhodesiense* epidemic areas or in highly endemic areas of *T. gambiense*; and (c) active case detection at least once a year is critical for the control of *T. gambiense* in each focus. Concerning the proposed targets, the Secretariat indicated that the work is ongoing, and with the willingness of partners and commitment of national governments, it is possible to achieve the stated targets.

74. The Subcommittee approved the document with amendments and prepared a draft resolution on the subject to be submitted to the Regional Committee for review and adoption.

CARDIOVASCULAR DISEASES IN THE AFRICAN REGION: CURRENT SITUATION AND PERSPECTIVES (document AFR/RC55/PSC/8)

75. Dr Rufaro Chatora of the Secretariat introduced the document on cardiovascular diseases.

76. The document has seven sections: introduction, situation analysis, challenges, opportunities, priority interventions, roles and responsibilities, and conclusion.

77. The burden of cardiovascular disease (CVD) is increasing rapidly in Africa, and it is now a public health problem throughout the Region. Complications occur at younger ages in developing countries. The current document takes cognizance of the strategic orientations

contained in the Global Strategy on Diet, Physical Activity and Health; WHO strategies on noncommunicable diseases and health promotion; and the Declaration of Heads of State of the Organisation of African Unity in Durban.

78. The most important CVDs are hypertension, stroke, cardiomyopathies and coronary heart disease. Rheumatic heart disease is still a major concern in the Region. One of the reasons for the increase of CVD in the world is linked to the aging of populations. The other reason is the exposure to behavioural and physiological risk factors. Eight of these are responsible for 75% of CVDs and have been prioritized by the WHO STEPS approach. The reason is based on their great impact on noncommunicable disease mortality and morbidity in general and CVD in particular; possibility of modification through primary prevention; and the availability of easy and standardized methods for measurement. As with other noncommunicable diseases, CVDs are not yet given the attention they deserve. As a result, most countries do not have national programmes or strategies to address CVD. Likewise, surveillance systems for CVD risk factors are almost non-existent in the Region.

79. Various priority interventions are aimed at reducing the burden of CVD in the Region. They include setting up a national NCD programme including CVD; setting up surveillance systems based on risk factors; capacity building of health personnel; ensuring availability of cost-effective medications for CVD; implementing the Framework Convention on Tobacco Control, the Global Strategy on Diet, Physical Activity and Health, and primary and secondary prevention of rheumatic heart disease.

80. The document concludes that cardiovascular diseases are a major public health concern in the Region. Key interventions need to be implemented promptly; high priority should be given to primary prevention (and health promotion); there is dire need for strong advocacy and high political commitment.

81. Members of the Subcommittee thanked the Secretariat for the document. They expressed the need to include the data, tables and conceptual graphic on the STEPS approach used in the presentation in order to enrich the document. Countries need to do more to reduce the risk of tobacco, as well as putting in place diagnostic and surveillance systems for other risk factors, including conducting surveys such as STEPS. Governments should create conducive environments to allow people to adopt healthy lifestyles as a major preventive strategy. Because of the lag between instituting prevention measures and seeing a declining trend in CVDs, there is a need for timely interventions such as adopting physical activity and proper diet. Participants requested to know the feasibility of incorporating STEPS into other national surveys, such as the Demographic and Health Surveys and general health surveys, to avoid fragmentation and duplication of efforts. Countries were encouraged to adopt policies on NCDs with a special emphasis on CVDs.

82. Members made the following specific suggestions for improving the document:

- (a) In the document, wherever “mortality” is referred to, “morbidity” should be included;
- (b) In paragraphs 29, 33 and 35, primary, secondary and tertiary preventions need to be explicitly described;
- (c) In paragraph 32, the document should give concrete proposals and recommendations for Member States;
- (d) In paragraph 38, the impact of social strife and instability should be included as part of the socioeconomic determinants;
- (e) In the section on Roles and Responsibilities, make paragraph 39(b) more explicit; in paragraphs 39 and 40, the importance of integration needs to be clearly understood; tell exactly how WHO could help to reduce the burden of CVDs as indicated in paragraph 40(b).

83. The Secretariat expressed appreciation for the comments and suggestions made by the Subcommittee and assured members that these would be included in the revised version. The available country data on STEPS would be used to update the document and for formulating cardiovascular disease policies as well as prevention and control programmes.

84. The challenge posed by noncommunicable diseases requires integration and a multisectoral response. NCD policies should be developed in the context of overall national health policies. It was explained that the integration of the STEPS surveys in national surveys was possible after adaptation. Relating to the role of WHO, the meeting was informed that the Secretariat would assist Member States with information, evaluation of risk factors, technical support and resource mobilization. By intervening in the eight risk factors, the incidence of NCDs in general would be reduced in an integrated manner. Members were informed that a website is available for results of the STEPS surveys and other relevant NCDs programmes in the Region.

85. The Subcommittee approved the document with amendments and prepared a draft resolution on the subject to be submitted to the Regional Committee for review and adoption.

IMPLEMENTATION OF THE FRAMEWORK CONVENTION ON TOBACCO CONTROL IN THE AFRICAN REGION: CURRENT STATUS AND THE WAY FORWARD

(document AFR/RC55/PSC/9)

86. Dr Rufaro Chatora of the Secretariat introduced the document on the Framework Convention on Tobacco Control. It has six sections: introduction, current status, challenges, opportunities, the way forward and conclusion.

87. Tobacco is the largest cause of preventable death globally and is estimated to kill 4.9 million people annually. It is the second major cause of death in the world. By 2020, tobacco will kill 10 million people per year, 70% in developing countries. In Africa, tobacco use prevalence was 29% in males and 7% in females in 2000. Being a major risk factor in cardiovascular disease and cancer, it adds to the double burden of disease in Africa, a region that is currently grappling with HIV/AIDS and malaria. The greatest public health impact of smoking on infection is the increased risk of tuberculosis, a particular problem in Africa.

88. The WHO Framework Convention on Tobacco Control was developed to counter the tobacco epidemic. On 27 February 2005 the Convention entered into force and became legally binding for the first 40 countries that became Contracting Parties before 30 November 2004, including five African countries. As of 1 June 2005, nine countries of the African Region ratified the Convention; seven have not signed and 30 are taking steps to ratify it.

89. Setting implementation goals and laying plans and strategies for the implementation of the Convention are imperative. Building a national plan and establishing legal and institutional framework to implement the action plan are key steps in implementing the Convention. The importance of public health should outweigh the economic importance of tobacco. Member States should take advantage of the recognized link between tobacco control and the achievement of the Millennium Development Goals.

90. Members of the Subcommittee thanked the Secretariat for the quality and timeliness of the document. They expressed regret that only nine countries out of 46 have ratified the Convention in the African Region. The situation is not encouraging since people in Africa are extremely vulnerable to advertisements by tobacco multinationals forced by stringent legislation in their countries of origin to relocate their tobacco production and sale activities to developing countries without similar legislation.

91. They expressed the need to: (i) urge Member States to hasten the ratification of the Convention so that they can have a voice in future international discussions related to tobacco control; (ii) set a deadline for ratification of the Convention by Member States in the African Region; (iii) intensify sensitization and advocacy among legislators in countries that have not ratified the Convention; (iv) intensify sensitization and advocacy among Heads of State

through the African Union to ensure that Africa does not lag behind in the prevention and control of noncommunicable diseases related to tobacco consumption; (v) intensify efforts to increase the number of countries ratifying the Convention; (vi) use the Regional Committee as a forum for joint African advocacy towards ratification; (vii) encourage countries to develop legislation on tobacco control (advertising, smoke-free places) and enforcement.

92. Members made the following specific suggestions for improving the document:

- (a) In the Introduction, paragraph 2, include lung cancer and highlight the linkage between tobacco and cardiovascular disease;
- (b) In the Current Status section, paragraph 9, update the number of countries that have ratified the FCTC;
- (c) In paragraph 20, first sentence, add the words “poverty alleviation” between “tobacco control” and “achievement of MDGs”;
- (d) In paragraph 21, include a sentence encouraging countries to ratify the Convention;
- (e) In the Conclusion, include a sentence urging countries that have not ratified the Convention to do so.

93. The Secretariat expressed appreciation for the comments and suggestions made by the Subcommittee and assured members that these would be included in the revised version. However, with regard to the specific issue of ratification, countries were urged to deposit the instrument of ratification at the UN treaty section in New York. It was emphasized that specific legislation on tobacco control should be consistent with the Convention. The primary consideration is on actions which should be in the public health interest.

94. The Subcommittee approved the document with amendments to be submitted to the Regional Committee for review and adoption.

REPRODUCTIVE CLONING OF HUMAN BEINGS: CURRENT SITUATION

(document AFR/RC55/PSC/10)

95. Dr Doyin Oluwole of the Secretariat presented the document on reproductive cloning. The document discusses the ethical concerns of reproductive cloning, potential benefits of non-reproductive cloning, current situation in the African Region, the way forward, monitoring and evaluation.

96. *Cloning* is a term generally used by scientists to describe different processes for duplicating biological material. A *clone* is an organism that is a genetic copy of an existing

one. Nuclear transfer is a technique used to duplicate genetic material by creating an embryo through the transfer and fusion of a diploid cell in an enucleated female oocyte. When nuclear transfer technique is applied for reproductive cloning of human beings, it is surrounded by strong ethical concerns and considered a threat to human dignity.

97. The international community has tried, over the years without success, to build a consensus on the issue of reproductive cloning of human beings. In February 2005, the Legal Committee of the United Nations General Assembly recommended to the Assembly the adoption of a declaration on human cloning. Member States were called upon to prohibit all forms of human cloning as they are incompatible with human dignity and the protection of human life.

98. The aim of this document is to create awareness among ministries of health in the African Region by providing them with critical and relevant information on the reproductive cloning of human beings and its implications to the health status of the population.

99. Some of the ethical concerns of reproductive cloning are related to the risk of causing physical, psychological or social harm; exploitation of the poor; and inequitable distribution of resources and inadequate attention to priority issues in the Region. The potential benefits of non-reproductive human cloning and nuclear transfer include the use of stem cells as replacement cells to treat some chronic diseases as well as to assist in drug development, diagnostic techniques, and the creation of cells and tissues for transplantation.

100. In most African countries, there are no specific regulations and policies regarding genetic manipulations for therapeutic, research and reproductive purposes. Consequently, there is an increased risk of undertaking illegal or unethical experiments and projects involving human reproduction.

101. To address these issues, countries should establish stringent policies and regulations and effective implementation and monitoring mechanisms, including national ethics review committees. WHO and partners are called upon to provide technical and financial support to countries to undertake the necessary actions. Member States are called upon to ensure that medical research proceeds in an ethical manner that protects human dignity.

102. Members of the Subcommittee welcomed the document and commended its quality and timeliness. They also highlighted the usefulness of the technical information contained in the document.

103. During the general discussions, the Subcommittee members highlighted the ongoing debate at national and international levels, and the fact that no consensus has been reached

up to now. The great debate is focused on the delineation between reproductive cloning of human beings and therapeutic cloning, and the ethical and moral implications of both.

104. The Subcommittee members reported on the last UN debate where three major positions were expressed, namely: rejecting all forms of cloning; allowing only therapeutic cloning; and calling for more discussion. Most of the African countries were in either the first or the third group.

105. Some African countries already have ethical review committees to advise on health research. WHO was called upon to support the strengthening of these committees to empower them to respond adequately to the emerging issues, such as human cloning and stem cell research, as well as to ensure follow-up of the UN Declaration.

106. Subcommittee members also recognized that the paper under discussion was largely an information paper. It provides the technical and scientific information needed for better participation in the ongoing international debate.

107. Members made the following specific suggestions for improving the document:

- (a) The Current Situation section should include information on countries that are already receiving substantial requests for establishment of a stem cell bank or laboratory, and information on countries with legal frameworks;
- (b) To paragraph 18, add: (e) Support countries to strengthen their capacity to implement the UN Declaration;
- (c) In paragraph 21, include the existing consensus on banning reproductive cloning of human beings and the absence of consensus on banning therapeutic cloning.

108. The Secretariat expressed appreciation for the comments and suggestions made by the Subcommittee and assured members that these would be included in the revised version. It was emphasized that the document, which provides up-to-date scientific and technical information, is for information and guidance to countries. It aims to empower countries to adequately engage in national and international debate. The paper is not prescriptive as to the position countries or Africa should take. The proposed roles and responsibilities of countries are meant to provide preventive measures, since the paper calls for actions that will allow countries to be better prepared to face the emerging challenges of human cloning and issues of ethical clearance for health research in general. The Subcommittee was also informed that the document is a response to a request made during the fifty-fourth session of the Regional Committee and that the Regional Office would support countries in setting up or strengthening the capacity of ethical review committees.

109. The Subcommittee approved the document with amendments to be submitted to the Regional Committee for review and adoption.

GUIDING PRINCIPLES FOR STRATEGIC RESOURCE ALLOCATIONS

(document AFR/RC55/PSC/11)

110. Dr Paul Lusamba-Dikassa of the Secretariat introduced the guiding principles document, which contained information about strategic resource allocation, guiding principles, the three perspectives, the validation mechanism and the process.

111. In 1998, Resolution WHA51.31 introduced a mechanism for resource allocation in the six regions of WHO. Subsequently, the budgets in Africa and Europe increased while the others decreased. The evaluation report was presented to the Fifty-seventh World Health Assembly where the four regions recommended discontinuing the existing formula for resource allocation at the end of 2005. Decision WHA57(10) asked the Director-General to develop a new formula based on equity, efficiency, performance and greatest need. The first draft was produced and presented to the one-hundred-and-fifteenth and one-hundred-and-sixteenth sessions of the Executive Board.

112. The guiding principles are presented in the context of proposed changes to the results-based managerial framework of WHO. They emphasize the need to allocate resources based on programmes, functions and perspectives. The document suggests the development of three main instruments to be used for determining resource allocation: a medium-term strategic plan (2008–2013); a strategic resource allocation principle and criteria; and a validation mechanism.

113. There are seven guiding principles for strategic resource allocation: allocation must be driven by expected organization-wide results; the budget should encompass all WHO financial resources; the planning process should be guided by the General Programme of Work and CCSs; relative resource indications should be defined for the full strategic planning period; past performance of specific programmes should be taken into account; three complementary perspectives should be considered—programmatic, functional and organizational; and finally, the planning process and results-based budget must be validated.

114. When completed, the validation mechanism will include parameters, indicators, indices and thresholds for resource allocation. The mechanism takes into consideration three components: The core component is related to the core functions of WHO; the engagement component reflects additional resources required for administrative functions; and the needs-based component reflects the health and socioeconomic status of countries served, and uses an index to inform additional resource allocation.

115. In summary, the document proposes (i) to link strategic resource allocation to the key managerial processes of the Organization: the General Programme of Work 2006–2015; a Medium-Term strategic plan 2008–2013; and Programme Budgets; (ii) to develop a validation mechanism; and (iii) to present the resource indication ranges emerging from the validation mechanism to the one-hundred-and-seventeenth session of the Executive Board.

116. The Programme Subcommittee acknowledged that this was an important document warranting a lot of time and analysis. However, the document was difficult to comprehend, and a lot of work would be needed to make it user-friendly before presentation to the Regional Committee. The document should clarify what the old formula of allocation was, and if the change is agreed upon, what benefits would accrue to the African Region. If this is part of general WHO reform, it should be stated in the document.

117. The Committee made the following specific suggestions for improving the document:

- (a) The Introduction should provide more background on the current formula and explain the essential components, itemize the core functions in the document, and indicate if core functions are only limited to Headquarters;
- (b) In paragraph 11, “results-based” management is subjective and may lead to disadvantaging regions and country offices;
- (c) In the section on Strategic Resource Allocation, add other principles such as the issue of fiscal decentralization—moving funds from HQ to the regions, long-term commitment, and predictability of resources from donors and Member States to facilitate strategic planning;
- (d) In paragraph 12, Principle 6, the question in the paragraph is rhetorical as it is known where work is best done;
- (e) In the section on Strategic Resource Allocation Along the Three Perspectives, indicate how flexible the allocation formula will be if priorities change and countries need to re-allocate funds;
- (f) In paragraph 17, seventh bullet, add “in the spirit of decentralization”;
- (g) In paragraph 24, last sentence, explain the relevance of categorization into “high, medium and low expected cost”;
- (h) In the section on The Validation Mechanism, paragraph 34, the last sentence needs revision: it seems contradictory since regions are not equal;
- (i) In paragraph 38, clarify the meaning of core component, and explain which level of WHO would be responsible for the core component and whether it would be funded from Voluntary funds or Regular budget;

- (j) In the section on Strategic Resource Allocation: the Process, paragraph 43, add “Regional Committee” after the HQ-based committees;
- (k) In paragraph 44, remove the word “note” and replace with “debate and adopt”; the process referred to in the subtitle should be elucidated, and it should be clear if rolling budgets will accompany the medium-term strategic plan.

118. The Secretariat thanked the Subcommittee for their comments and informed them that this was a document that is still evolving. It is part of the general WHO reform and responds to the current context wherein the bulk of the budget is based on Voluntary funds. Consultations are going on in all regions before its finalization, and more work needs to be done on matters such as indicators and weighting. The previous formula was based on the bulk of the funding coming from the Regular budget. The participants expect that the new approach will not result in a disadvantage for the African Region, given that it has more countries to support and greater needs than all the other regions.

119. The ministers of health of the African Region discussed an earlier draft of the document during the WHA and took a position on the matter, and that document is available. They requested an opportunity for further analysis from the regions; hence the document will be tabled in the Regional Committee. By then it will have been modified to include input and issues from this PSC meeting report which will be shared with the Task Force drafting the document.

HIV PREVENTION IN THE AFRICAN REGION: A CALL FOR ACCELERATED ACTION

120. The Regional Director submitted the document “HIV Prevention in the African Region—A Call for Accelerated Action”, providing a brief summary of the HIV/AIDS situation in the Region and emphasizing the urgent need for intensified action on prevention. He asked for the Committee’s advice on the proposal to declare the year 2006 as “Year of Acceleration of HIV Prevention in Africa” with a view to presenting the matter to the Regional Committee for endorsement. This is in line with the function of the Programme Subcommittee to counsel the Regional Director as and when appropriate between sessions of the Regional Committee.

121. The Programme Subcommittee unanimously supported the initiative of accelerating HIV prevention and declaring 2006 a year of special focus. They highlighted certain aspects to be emphasized in the document and in the proposed Round Table for the fifty-fifth session of the Regional Committee. The aspects include:

- (a) An in-depth analysis and understanding of why efforts to control HIV in the region have so far not been successful;
- (b) An understanding of the factors related to the difference in the situation between countries in Africa, and between Africa and other continents;
- (c) A focus on behaviour change which would enable people to translate knowledge into protective behaviour;
- (d) The need to develop approaches to monitoring incidence in addition to prevalence in order to demonstrate the impact of prevention interventions;
- (e) Ensuring that the decision on this initiative is incorporated in the UN Secretary-General's speech to the General Assembly in September 2005;
- (f) While focusing on prevention, continuing the emphasis on improving access to treatment for people living with HIV/AIDS;
- (g) Emphasizing PMTCT as well as interventions targeting intravenous drug users;
- (h) Addressing the needs of orphaned children, particularly building on the theme of the Day of the African Child in 2005 which is on protection from HIV;
- (i) Ensuring integration and coordination as key principles in the implementation of the initiative;
- (j) Highlighting the new strategies and approaches which are proposed in order to make the difference;
- (k) Defining the timeline, including the commemoration day, in the proposal to be submitted to the Regional Committee.

122. The Regional Director thanked the Programme Subcommittee for their support for the initiative. He indicated that HIV prevention would be discussed in a Round Table during the fifty-fifth session of the Regional Committee. He also reported that he had organized a multidisciplinary consultation on HIV prevention, and that the report with many innovative recommendations would be shared with members of the Programme Subcommittee. Following the endorsement of the Committee, he promised to publicly announce the initiative and submit the proposal to the Regional Committee.

123. The Subcommittee endorsed the declaration of the year 2006 as "Year of acceleration of HIV prevention in Africa" and recommended that the Regional Committee adopt this initiative.

GLOBAL MINISTERIAL CONFERENCE ON HEALTH RESEARCH, 2008

124. The Regional Director presented the document, "Invitation to make offers to host the Global Ministerial Conference on Health Research, 2008". It was recalled that the Fifty-eighth World Health Assembly examined and discussed the Mexico Declaration on Health Research and later adopted a related resolution entitled "World Summit on Health Research". The World Health Assembly adopted the proposal made by the Mexico Ministerial Summit to hold the 2008 Ministerial Conference in the WHO African Region. Furthermore, the Regional Director mentioned that the 2008 Ministerial Conference aimed to promote research culture and practice and to generate knowledge and use it as a precondition for achieving health goals at national and international levels in order to improve the performance of national health systems and strengthen the socioeconomic development of countries. The Programme Subcommittee welcomed the holding of the Global Ministerial Conference in the African Region and commended the process of consultation with Member States to identify and choose the country that would host the event.

125. The Subcommittee accepted the criteria proposed for selecting the host country and proposed to the Regional Director a list of countries that should be considered in the process of consultation with governments. The countries thus proposed were Algeria, Kenya, Mali, Mozambique, Nigeria, Rwanda, Senegal and South Africa.

126. The issue would be referred to the next session of the Regional Committee for decision.

ADOPTION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE

(document AFR/RC55/PSC/12)

127. After a review of the document and some discussions and amendments, the Programme Subcommittee adopted the report as amended.

ASSIGNMENT OF RESPONSIBILITIES FOR THE PRESENTATION OF THE REPORT OF THE PROGRAMME SUBCOMMITTEE TO THE REGIONAL COMMITTEE

128. The Programme Subcommittee decided that its Chairman and the Rapporteurs would present the report to the Regional Committee, and that in the event that any of the Rapporteurs were unable to attend the Regional Committee, the Chairman would present that section of the report.

129. The assignment of responsibilities for presentation of the report to the Regional Committee was as follows:

- (a) WHO Programme Budget 2006–2007: Orientations for implementation in the African Region
Prof. Mohammed Lemine Ba (Chairman)
- (b) Country cooperation strategies: Implementation, lessons learnt and the way forward in the African Region
Prof Mohammed Lemine Ba (Chairman)
- (c) Achieving health Millennium Development Goals: Situation analysis and perspectives in the African Region
Prof Mohammed Lemine Ba (Chairman)
- (d) Local production of essential medicines, including antiretrovirals: Issues, challenges and perspectives in the African Region
Dr Boureima Hama Sambo (Rapporteur)
- (e) Control of human African trypanosomiasis: A strategy for the African Region
Dr Boureima Hama Sambo (Rapporteur)
- (f) Cardiovascular diseases in the African Region: Current situation and perspectives
Dr Habib Saizi Somanje (Rapporteur)
- (g) Implementation of the Framework Convention on Tobacco Control in the African Region: Current status and the way forward
Dr Habib Saizi Somanje (Rapporteur)
- (h) Reproductive cloning of human beings: Current situation
Dr Alexandre Manguéle (Rapporteur)
- (i) Guiding principles for strategic resource allocations
Dr Alexandre Manguéle (Rapporteur)

CLOSURE OF THE MEETING

130. Professor Mohammed Lemine Ba, Chairman of the Programme Subcommittee, thanked the members for facilitating his role. He thanked Subcommittee Members for their patience, attentiveness, active participation and cooperation throughout the meeting. He commended the Regional Director and the staff for the quality and relevance of the documents presented which facilitated discussion.

131. The Chairman informed the meeting that the term of Madagascar, Malawi, Mali, Mauritania, Mauritius and Mozambique as members of the Programme Subcommittee had

come to an end. He thanked them for their diligent contribution to the work of the Subcommittee. They will be replaced by Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania and Togo.

132. The Regional Director thanked the Chairman for his able leadership throughout the meeting, and the members of the Subcommittee for their excellent contributions and guidance which would serve to enrich the documents. He assured the Subcommittee that their suggestions and recommendations would be taken into account when revising the documents for further discussion at the fifty-fifth session of the Regional Committee. He appreciated the indulgence of the Subcommittee for considering two items which were not on the agenda.

133. The Regional Director thanked the members of the Subcommittee, the interpreters and translators and the Secretariat for their excellent work which had contributed to making the meeting a success.

134. The Chairman then declared the meeting closed.

LIST OF PARTICIPANTS

**1. MEMBER STATES OF
SUBCOMMITTEE**

MADAGASCAR

Prof. Erline H. Rasikindrahona
Directeur de la Promotion de la Santé

MALAWI

Dr Habib Saizi Somanje
Director of Preventive Health Services

MALI

Dr Sidy Diallo
Conseiller technique du Ministère de la
Santé

MAURITANIA

Prof. Mohammed Lemine Ba
Conseiller technique du Ministre de la
Santé

MAURITIUS

Mr Yogendr'nath Ramful
Senior Principal Health Economist

MOZAMBIQUE

Dr Alexandre Lourenço Jaime Manguela
Assessor do Ministro de Saúde

NAMIBIA

Dr Norbert P. Forster
Under Secretary, Health and Social
Welfare Policy

NIGER

Dr Boureima Hama Sambo
Directeur de la Santé

NIGERIA

Dr Shelu Sule
Director, Health Planning and Research

RWANDA

Dr Eliphaz Ben Karenzi
Secrétaire général du Ministère de la Santé

SAO TOME AND PRINCIPE

Dr José Manuel de Jesus Alves Carvalho
Coordenador da Direcção-Geral dos
Cuidados de Saúde

SENEGAL

Dr Babacar Dramé
Directeur de la Santé

**2. AFRICAN ADVISORY COMMITTEE
FOR HEALTH RESEARCH AND
DEVELOPMENT (AACHRD)**

Dr Shyam Shunker Manraj
Consultant (Pathology Services)
Central Health Laboratory, CANDOS
Victoria Hospital, Mauritius
Chairman of AACHRD

3. OBSERVER

Ms Dedeh Jones*
Chief Nursing Officer of the Ministry of
Health and Social Welfare
Liberia

* Unable to attend

AGENDA

1. Opening of the meeting
2. Election of the Chairperson, the Vice Chairperson and the Rapporteurs
3. Adoption of the Agenda (document AFR/RC55/PSC/1)
4. WHO Programme Budget 2006-2007: Orientations for implementation in the African Region (document AFR/RC55/PSC/3)
5. Country cooperation strategies: Implementation, lessons learnt and the way forward in the African Region (document AFR/RC55/PSC/4)
6. Achieving health Millennium Development Goals: Situation analysis and perspectives in the African Region (document AFR/RC55/PSC/5)
7. Local production of essential medicines, including antiretrovirals: Issues, challenges and perspectives in the African Region (document AFR/RC55/PSC/6)
8. Control of human African trypanosomiasis: Strategy for the African Region (document AFR/RC55/PSC/7)
9. Cardiovascular diseases in the African Region: Current situation and perspectives (document AFR/RC55/PSC/8)
10. Implementation of the Framework Convention on Tobacco Control in the African Region: Current status and the way forward (document AFR/RC55/PSC/9)
11. Reproductive cloning of human beings: Current situation (document AFR/RC55/PSC/10)
12. Guiding principles for strategic resource allocations (document AFR/RC55/PSC/11)
13. Adoption of the Report of the Programme Subcommittee (document AFR/RC55/PSC/12)
14. Assignment of responsibilities for the presentation of the Report of the Programme Subcommittee
15. Closure of the meeting

APPENDIX 3

PROGRAMME OF WORK

DAY 1: TUESDAY, 14 JUNE 2005

10.00 a.m. - 10.10 a.m.	Agenda item 1	Opening of the meeting
10.10 a.m. - 10.20 a.m.	Agenda item 2	Election of the Chairman, the Vice-Chairman and the Rapporteurs
10.20 a.m. - 10.30 a.m.	Agenda item 3	Adoption of the Agenda (document AFR/RC55/PSC/1)
10.30 a.m. - 11.00 a.m.	<i>Tea break</i>	
11.00 a.m. - 12.30	Agenda item 4	WHO Programme Budget 2006-2007: Orientations for implementation in the African Region (document AFR/RC55/PSC/3)
12.30 - 2.00 p.m.	<i>Lunch break</i>	
2.00 p.m. - 4.00 p.m.	Agenda item 5	Country cooperation strategies: Implementation, lessons learnt and the way forward in the African Region (document AFR/RC55/PSC/4)

DAY 2: WEDNESDAY, 15 JUNE 2005

09.00 a.m. - 10.30 a.m.	Agenda item 6	Achieving health Millennium Development Goals: Situation analysis and perspectives in the African Region (document AFR/RC55/PSC/5)
10.30 a.m. - 11.00 a.m.	<i>Tea break</i>	

11.00 a.m. - 12.30	Agenda item 7	Local production of essential medicines, including antiretrovirals: Issues, challenges and perspectives in the African Region (document AFR/RC55/PSC/6)
12.30 - 2.00 p.m.	<i>Lunch break</i>	
2.00 p.m. - 4.00 p.m.	Agenda item 8	Control of human African trypanosomiasis: A strategy for the African Region (document AFR/RC55/PSC/7)
5.00 p.m.	<i>Cocktail</i>	

DAY 3: THURSDAY, 16 JUNE 2005

09.00 a.m. - 10.30 a.m.	Agenda item 9	Cardiovascular diseases in the African Region: Current situation and perspectives (document AFR/RC55/PSC/8)
10.30 a.m. - 11.00 a.m.	<i>Tea break</i>	
11.00 a.m. - 12.30	Agenda item 10	Implementation of the Framework Convention on Tobacco Control in the African Region: Current status and the way forward (document AFR/RC55/PSC/9)
12.30 - 2.00 p.m.	<i>Lunch break</i>	
2.00 p.m. - 4.00 p.m.	Agenda item 11	Reproductive cloning of human beings: Current situation (document AFR/RC55/PSC/10)
4.00 p.m. - 5.00 p.m.	Agenda item 12	Guiding principles for strategic resource allocations (document AFR/RC55/11)

DAY 4: FRIDAY, 17 JUNE 2005

09.00 a.m. - 4.00 p.m.	Writing report	(by the Secretariat)
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4.00 p.m.

Agenda items (13, 14, 15)

- Adoption of the Report of the Programme Subcommittee (document AFR/RC55/PSC/12)
- Assignment of responsibilities for the presentation of the Report of the Programme Subcommittee to the Regional Committee
- Closure of the meeting.

REPORT OF THE ROUND TABLE

HIV and AIDS prevention in the African Region

Introduction

1. The Round Table on Prevention of HIV and AIDS in the African Region was held on 23 August 2005 under the chairmanship of Dr Alex Kamugisha, Minister of State for Health, Uganda. In his introductory remarks, he recalled the consultation on HIV prevention convened by the Regional Director in Brazzaville, Republic of Congo in June 2005 and the recommendations of the Programme Subcommittee to accelerate HIV prevention efforts in the African Region.

2. The facilitator was Dr Olive Shisana, President and Chief Executive Officer of the Human Sciences Research Council of South Africa. She gave an overview of the HIV and AIDS situation in Africa, highlighting the factors accounting for the increasing trends in new infections, the key challenges in addressing the epidemic and the recommendations of the Brazzaville consultation on HIV prevention.

Discussion points

3. The Round Table discussed the following questions:
- (a) What specific actions can ministers of health take to re-invigorate HIV prevention in order to bring a sense of urgency?
 - (b) What concrete actions can ministers of health take to ensure that HIV-prevention interventions targeting the youth and other vulnerable groups are expanded?
 - (c) What practical steps are the ministers of health going to take to promote greater involvement of the communities, community-based organizations, nongovernmental organizations, faith-based organizations, and people living with HIV/AIDS in HIV prevention efforts?
 - (d) What practical steps are to be taken for 2006, the Year of Acceleration of HIV Prevention in the African Region?

Contributions

4. Participants from 45 countries and 10 partner organizations took part in the Round Table. A total of 20 contributions were made. All participants recognized that HIV and AIDS are major development challenges that deserve special attention, and they unanimously endorsed the Regional Director's proposal to declare 2006 the Year of Acceleration of HIV Prevention in the African Region.

Recommendations

5. The Round Table made the following recommendations:

- (a) To ensure effective advocacy and action-oriented leadership by ministries of health;
- (b) To urgently re-emphasize and re-invigorate HIV prevention efforts, ensuring that appropriate targets are set;
- (c) To accelerate the implementation of multisectoral responses while ensuring effective coordination and harmonization of HIV prevention efforts;
- (d) To increase access to quality health-sector-based prevention interventions by strengthening health systems;
- (e) To scale up prevention programmes which target the youth, women, girls and other vulnerable groups, including sex workers;
- (f) To implement health promotion programmes that help individuals to move from awareness and improved knowledge to positive change in sexual behaviour;
- (g) To mount social mobilization programmes that ensure ownership by communities and use of local resources;
- (h) To address the issues of stigma, discrimination, and negative cultural values and practices;
- (i) To link the scaling up of treatment with HIV prevention;
- (j) To promote local research for a better understanding of the dynamics of HIV transmission in order to mount appropriate responses;
- (k) To intensify partnerships between governments and private sector and civil society organizations, including associations of people living with HIV and AIDS;
- (l) To develop appropriate policies and legislation to create a supportive environment for scaling up HIV prevention interventions;

- (m) To mobilize and allocate adequate resources to facilitate the scaling up of HIV prevention interventions;
- (n) To strengthen monitoring and evaluation of HIV prevention efforts;
- (o) To advocate for acceleration of efforts aimed at the development of preventive technologies such as microbicides and HIV vaccines;
- (p) To continue to collaborate with research institutions and partners in order to assess the effectiveness of male circumcision in the prevention of HIV infection.

ANNEX 6

REPORT OF THE PANEL DISCUSSION

Social determinants of health and health inequalities: A matter of concern in the African Region

Introduction

1. The Panel Discussion on social determinants of health and health inequalities in the African Region was held on 25 August 2005 under the Chairmanship of Dr Zeinab Mint Youba-Maïga, the Minister of Health, Mali. In her introductory remarks, she pointed out that many countries in the African Region and worldwide experience inequalities in health that are within social and human control. Moreover, these inequalities were growing despite unprecedented global wealth, knowledge and health awareness. Yet, health policies were dominated by disease-focused solutions that largely ignored the social environment. As a result, health problems have persisted, inequalities have widened, and health interventions have obtained less than optimal results.

2. WHO is interested in measuring health inequality as a distinct dimension of the performance of health systems. There is evidence that appropriate policy, action and leadership to address the social dimensions of health can improve health and access to health care. It is in this context that at the Fifty-eighth World Health Assembly, Dr Jong-wook Lee, WHO Director-General, called for the formation of the Commission on Social Determinants of Health (CSDH). The Commission, charged with recommending interventions and policies to improve health and narrow health inequalities through action on social determinants, was launched on 17 March 2005 in Santiago, Chile. The Minister also pointed out that in order to achieve the health-for-all policy goals for the 21st century in the African Region by 2020, there was urgent need to reduce the health inequalities and inequities in the Region, hence the current panel discussion.

Discussion points

3. The group discussion discussed the following key questions:
- (a) Are there any documented aspects of avoidable inequalities? If yes, along what dimensions? If no, why? Could it be due to lack of data? What needs to be done to identify the extent of avoidable inequalities in the country?
 - (b) What has been done about existing avoidable inequalities?

- (c) What other information is needed in order to document and act on avoidable inequalities?

4. The panellists were the ministers of health from the Democratic Republic of Congo, Malawi and Uganda. They focused on inequalities relating to maternal and child health, including IMCI; malaria; and HIV/AIDS, sexually transmitted infections and tuberculosis. There was no presentation on health systems because the invited panellist had not received the communication in time.

Contributions

5. The Minister of Health, Kenya, in a paper read on her behalf by Dr James Nyikal, Director of Medical Services, highlighted the plight of vulnerable people and raised substantive issues relating to factors responsible for inequalities in health. The paper further elucidated the role of poverty and the unequal distribution of wealth. It also outlined the objectives and methodology of the CSDH.

6. Dr Pascoal Mocumbi, a CSDH Commissioner and WHO African Region Goodwill Ambassador for maternal, newborn and child health, gave a brief on the Brazzaville meeting of the CSDH in the African Region. The Commission noted that there was under-investment in health in the Region and called on countries to urgently address issues related to health systems and human resources for health. He called on the Regional Committee to take ownership of the work of the Commission in the African Region.

7. The panellists and eight debaters outlined factors responsible for health inequalities in their respective countries. All invariably mentioned poverty. Other factors were globalization; conflicts; the physical and social environments in which most people live; social, economic, cultural and demographic determinants.

8. Some actions taken in individual countries to address the issue of inequalities were also outlined, including:

- (a) For maternal and newborn health:
 - (i) Assisting births
 - (ii) Providing emergency obstetric care
 - (iii) Increasing ambulances
 - (iv) Dealing with cultural beliefs
 - (v) Providing traditional midwives with training and delivery kits
 - (vi) Involving traditional leaders in assisting women in labour and carrying out maternal and child death audits

- (vii) Nutritional programmes
- (viii) Social grants
- (ix) Adoption of the roadmap to safe motherhood.

(b) For malaria:

- (i) Insecticide-treated nets
- (ii) Indoor residual spraying
- (iii) Provision of drugs for vulnerable populations.

(c) For HIV/AIDS, STIs and tuberculosis: Provision of free ARVs.

9. Panellists and delegates contributing to the debate suggested several actions and interventions for moving forward:

- (a) Initiating change by providing information and advocating for the implementation of effective global and national policies that target social determinants of health
- (b) Intersectoral collaboration involving governments, NGOs, politicians and other stakeholders
- (c) Setting up intersectoral working groups involving policy-makers, civil society, various ministries, and academics and mobilization of the political leadership and partnerships to ensure that pro-poor policies are supported
- (d) Fair sharing of resources through appropriate policies, especially empowering the poor through land ownership and employment, among others
- (e) Providing healthy working environments, opportunities for employment and fair wages
- (f) Resource mobilization
- (g) Addressing the issue of human rights
- (h) Adoption of policies that promote solidarity
- (i) Developing resource allocation mechanisms that favour disadvantaged areas and groups
- (j) Health sector reform that strengthens the health system
- (k) Use of SWAps
- (l) Increased advocacy
- (m) Formation of sector advisory groups to foster multisectoral collaboration
- (n) Adoption of close-to-client systems, e.g. introduction of health posts in villages

- (o) Providing access to education
- (p) Addressing gender disparities.

Challenges

10. Panellists and contributing delegates mentioned various challenges, including lack of resources, selfishness on the part of the rich and lack of political will.

Recommendations

11. Noting the close relationship between health and social well-being, ministers and delegates called upon the WHO Regional Office to develop a regional strategy which would outline the roles of countries in the work of the CSDH.

12. Member States underscored the need to implement the recommendations of the WHO Commission on Macroeconomics and Health, particularly the preparation of pro-poor health investment plans, to address health inequalities.

REPORT OF THE SPECIAL SESSION

Sustainable health financing in Africa

Background

1. Dr Alimata Diarra-Nama, Director, Division of Health Systems and Services Development, welcomed all the delegates, invited guests and the Secretariat to the special session on sustainable health financing in Africa. She expressed thanks to the World Bank and the International Monetary Fund for honouring the Regional Director's invitation to collaborate in holding the special session. She also thanked the panellists for accepting to share their experiences at the session.

2. She said that in the course of the various meetings of the fifty-fifth session of the Regional Committee, the delegates had discussed what countries needed to do to scale up efforts to achieve the MDGs. Further, she added that this session would discuss how to fund the efforts needed to achieve the MDGs and the macroeconomic challenges that countries need to face.

3. She underscored that health system financing is very important since it affects the performance of not only its other functions of stewardship, resource creation and provision of services but also the achievement of health system goals—health, responsiveness to people's non-medical expectations and fair financial contributions.

4. She alerted the delegates that as they proceed with their discussions, it was important to remember that the objectives of health financing were to make funding available, ensure choice of cost-effective interventions, set appropriate financial incentives for providers, and ensure that all individuals have access to effective public health and personal health care. She recalled that health financing had three functions: revenue collection, pooling of resources and purchasing of health services.

5. She said that the general objective of the special session was to reinforce dialogue between the WHO Regional Office for Africa, the World Bank, the International Monetary Fund (IMF) and ministers of health on the key health financing challenges faced by the WHO African Region. The specific objectives of the session were:

- to agree on strategies and approaches to address health financing challenges in the Region;

- to discuss financial policies and tools which could enable countries to meet the resource requirements for achieving the health Millennium Development Goals.

6. Dr OK Pannenberg thanked the Regional Director for inviting the World Bank and IMF to dialogue with the delegates at the fifty-fifth session of the WHO Regional Committee for Africa.

7. This session was divided into two parts. The first part discussed health financing challenges and recent reforms. The second part focused on fiscal space issues in designing poverty-reducing expenditures.

Part I: Health financing challenges and recent reform trends in the African Region

8. The first part was chaired by Dr Hetherwick Ntaba, Minister of Health for Malawi. This part reviewed the key health financing challenges faced at country level in the Region as well as recent trends for addressing these challenges. It began with a brief presentation entitled “Health financing challenges and recent reform trends in the African Region” by Dr Alexander Preker of the World Bank.

9. Muhammed Lecky, Executive Director, National Health Insurance Scheme, Nigeria, gave a presentation entitled “Nigerian national health insurance scheme: A key strategic response to health care financing”. Dr Sam Akoa, Executive Secretary, National Health Insurance Council, Ghana, gave a presentation entitled “National health insurance scheme, Ghana”. In the discussions that ensued between panel members and delegates, a number of challenges and recommendations emerged.

Issues and challenges

10. Issues and challenges were stated in the form of questions:

- (a) How can cross-subsidization be achieved in a fragmented situation in Nigeria?
- (b) How can countries introduce social health insurance (SHI) in situations where: (i) there is a dearth of relevant human (administrative and managerial) and institutional capacities; (ii) a sizable proportion of the population live below the poverty line of US\$ 1 per day; (iii) informal sectors predominate; (iv) there is substantive opposition from the private medical industry?
- (c) Are SHI schemes financially feasible, given their high administrative costs? How can countries that are in the process of introducing SHI contain the cost?

- (d) How can promotive and preventive services be funded within national health insurance programmes?
- (e) How can countries pay for improvement in the quality of public health services to make them attractive to those who are able to pay?
- (f) How can countries undertake massive expansion in coverage of MDG-related health services with the budgetary ceilings imposed by the IMF?

Recommendations

11. WHO and development partners (World Bank and IMF) should support countries:
 - (a) to strengthen health financing and financial management capacities;
 - (b) to develop comprehensive pro-poor health financing policies and strategies;
 - (c) to undertake financial feasibility analyses to ascertain whether contemplated financing reforms are viable or non-viable;
 - (d) to undertake and institutionalize national health accounts;
 - (e) to develop mechanisms for coordinating health sector financial support from various sources.

Part II: Understanding fiscal space issues in designing poverty reducing expenditure

12. The second part of the special session was chaired by Dr Lea Koyassoum-Doumta, Minister of Public Health and Population, Central African Republic. This part examined efforts by the international donor community (development partners) to assist Member countries to resolve their health financing challenges.

13. Part II began with a presentation by Mr Perone, IMF Country Representative, Mozambique. It was entitled "Understanding fiscal space: Issues in designing poverty reducing expenditures". The presentation posed the following questions: What is fiscal space? What are the fiscal space issues in designing poverty-reducing expenditure programmes? How can countries create more fiscal space? How is fiscal space linked to the concept of sustainability?

14. He mentioned a number of ways of increasing fiscal space, e.g. increasing revenues through additional taxation, prioritization of expenditures, increased borrowing, increased grants, implementing sound macroeconomic management.

15. The panellists of Part II were Dr Tim Evans, Assistant Director General, EIP/HQ; and Dr Emmanuel Reynaud, Chief, Social Protection Branch, International Labour Organization. In the discussions that ensued between panel members and delegates, a number of challenges and recommendations emerged.

Issues and challenges

16. Various issues and challenges appeared as questions:

- (a) Are current fiscal space policies working for the health sector?
- (b) Are investments in health economically productive?
- (c) How can countries support training institutions to produce more human resources, employ the needed extra human resources for health or increase retirement age in the face of the macroeconomic ceilings imposed by the IMF?
- (d) How can the terms and conditions of health workers be improved in order to attract and retain them without impinging on fiscal space?
- (e) How can countries increase investments in medicine, medical technology and health infrastructure without violating fiscal space?
- (f) How can countries introduce compulsory prepaid financing mechanisms without violating fiscal space?

Recommendations

17. Various recommendations followed:

- (a) IMF should support countries to create the necessary fiscal space in order to purchase or produce the health inputs required in the achievement of MDGs,
- (b) The World Bank and IMF should advocate for alignment and harmonization of donor funding to reduce the administrative cost of aid,
- (c) WHO and World Bank should support countries to institutionalize mechanisms for monitoring efficiency in the use of health sector resources.

ANNEX 8

SPEECH BY PROF PAULO IVO GARRIDO MINISTER OF HEALTH, MOZAMBIQUE

Your Excellency, President of the Republic of Mozambique,
WHO Director-General, Dr Jong-wook Lee,
WHO Regional Director for Africa, Dr Luis Gomes Sambo,
Excellencies, members of the diplomatic corps,
Distinguished guests,
Delegates,
Ladies and gentlemen,

I feel honoured and privileged to have the opportunity to address this gathering at the opening of the fifty-fifth Session of the WHO Regional Committee for Africa.

Your Excellency, President of the Republic, permit me to convey warm greetings to everyone present here. Permit me also to express the great satisfaction and honour that we feel for hosting, in Maputo, capital of Mozambique, the fifty-fifth session of the WHO Regional Committee for Africa which will be discussing the main health problems in the African Region.

With great joy and emotion, I welcome everyone here to Maputo.

I wish to convey special regards to Dr Jong-wook Lee, the WHO Director-General. We, the health workers of Mozambique, feel particularly honoured indeed, to have, in our presence, the United Nations most senior official in the area of health.

I wish also to congratulate Dr Luis Gomes Sambo, the WHO Regional Director, on his assumption of his new office. May I use the occasion to welcome him to Maputo and to reassure him of our full support in running this meeting which has so much importance for the health of our people.

I should like to welcome to Maputo the honourable ministers of health of countries of the African Region, representatives of international organizations and other distinguished personalities present at this gathering.

Your Excellency the President,

Your presence in this room gives evidence of the importance that our government attaches to health as the pillar of human development and the cornerstone of the eradication of absolute poverty in our countries. I would like to thank you, Mr President, for having graced with your presence the fifty-fifth session of the WHO Regional Committee for Africa.

May I use this opportunity to reiterate Mozambique's commitment to ensuring that the fifty-fifth session of the WHO Regional Committee for Africa proceeds under the best of conditions.

I would conclude my address by wishing all participants success in your deliberations and urging you to feel very much at home in Maputo.

Thank you.

ANNEX 9

SPEECH BY DR SALEH MEKY, MINISTER OF HEALTH, ERITREA, CHAIRMAN OF THE FIFTY-FOURTH SESSION OF THE WHO REGIONAL COMMITTEE FOR AFRICA

Your Excellency, President of the Republic of Mozambique,
Your Excellency, Mr Alpha Omar Konaré, Chairman of the African Union Commission,
My colleagues, the honourable ministers of health,
Director-General of WHO, Dr Jong-wook Lee,
The WHO Regional Director for Africa, Dr Luis Gomes Sambo,
Distinguished ladies and gentlemen,

Allow me, first of all, to thank you all for the honour bestowed on me and my country, Eritrea, to chair the Regional Committee for Africa during the past year.

During the past twelve months, we noticed greater attention being paid to diseases of poverty, which are also the three most important communicable diseases in Africa, namely malaria, tuberculosis and HIV/AIDS. Following the Abuja Declaration on the Roll Back Malaria initiative, many countries have made progress towards the achievement of the initiative targets.

The prevalence of tuberculosis in our Region is increasing as a result of the HIV/AIDS pandemic. Although tuberculosis is a curable disease, most of our people do not have easy access to care due to the high level of poverty in our countries. We therefore need to assist individuals to have access to quality, cost-effective care in a decentralized and community-focused health care system.

In order to scale up evidence-based interventions for poverty-related diseases in our Region, the Division of HIV/AIDS, Tuberculosis and Malaria (ATM) has been set up in the Regional Office. To date many African countries have made significant achievements in the control of these diseases. However, much remains to be done in an integrated manner for an efficient use of our scarce resources.

The inauguration of the Commission on Social Determinants of Health initiated by Dr Jong-wook Lee, the Director-General of the World Health Organization, and hosted by the Government and people of the Republic of Chile is another significant event of this year. The Honourable Minister of Health of Kenya presented the African position at this ceremony. The

Regional Director and myself also participated in the proceedings. The Honourable Minister from Kenya was nominated as permanent member of the Commission. In July this year, the WHO Regional Office for Africa hosted the Regional Consultation on Social Determinants of Health. All members of the Commission were in attendance and noted the views of the experts in our Region on this matter.

Following the launching and adoption of the Millennium Development Goals, all Member States are currently actively implementing activities for the achievement of the millennium development targets. To fully achieve the proposed targets, there is a need for concerted effort by all Members States, especially in the implementation of the health targets which are of direct interest to us here. Additional funding is definitely required, though our collective approach and joint action will assure our success in this endeavour.

To meet these goals, our recent experience in Geneva is of particular significance. Despite our understandable differences in approach, geographical location and economic as well as political organizations, the common regional approach that we are attempting to undertake on important global health issues is encouraging.

Indeed, during the Fifty-eighth World Health Assembly held in Geneva in May this year, we presented a common African position regarding issues relating to maternal and newborn health, HIV/AIDS, human resource development in the African Region and health care financing. This position, which was arrived at by consensus built during the regular consultative meetings that we held every morning before the Assembly sessions, helped forge a close relationship between our countries, and hopefully fostered the need and demonstrated the mutual benefit of helping each other by taking a common stand which will enable us to project a united front for Africa on critical health-related issues.

This, in my view, is one of the most promising developments in our common struggle to control the burden of diseases in our respective States and lessen the suffering of our peoples.

It would seem prudent, then, to encourage this healthy trend in the interest of all regional Member States by strengthening our unity and promoting a Regional voice in identifying the commonality of activities related to health care financing, human resources for health and decentralization which are issues of major significance to be addressed in the coming year.

Our WHO Regional Office for Africa has demonstrated its ability to help achieve this goal effectively and efficiently if we give it the support and genuine participatory goodwill it surely requires.

Distinguished ladies and gentlemen, since the election of Dr Luis Gomes Sambo, a national of the Republic of Angola, as the new WHO Regional Director for Africa, many developments have been taking place. Among these are the restructuring of the WHO Regional Office for Africa and plans to strengthen the WHO country offices. This is a welcome development for us in the ministries of health. In addition, vigorous resource mobilization measures aimed at funding priority programmes are currently being pursued by the new Regional Director for Africa.

The implementation of the Country Cooperation Strategies (CCSs) that is currently receiving the attention of the Regional Office is a welcome development. The implementation of the CSS will definitely address our country-specific priorities. We therefore encourage all levels of the WHO to continue the current re-profiling activities in order to address the priority components in the CSS of various countries.

Mr Chairman, honourable ministers,
Distinguished ladies and gentlemen,

We are coming to the end of the 2004-2005 biennium and are preparing the 2006-2007 biennial workplan. This is the opportunity for us to address some of the gaps we have been noticing over the years and to avoid repeating the same mistakes. In this regard, I would like to call on the Regional Director to ensure the preparation of better biennial plans which would take into consideration the funding of our priority programmes as well as the availability of technical experts to assist our ministries of health.

Mr Chairman, before I conclude, I would like to take this opportunity to thank my colleagues for their support during the past 12 months and to congratulate the in-coming Chairman and wish him a successful tenure. I would like to assure him of my support and cooperation at all times.

In the same spirit, allow me to thank the people and Government of Mozambique for warmly welcoming us to their beautiful and exciting city of Maputo, and the President of the Republic for honouring us with his presence among us here today.

Finally, I wish you all fruitful deliberations during the fifty-fifth session of the WHO Regional Committee for Africa.

Thank you for your attention.

SPEECH BY DR LUIS GOMES SAMBO, WHO REGIONAL DIRECTOR FOR AFRICA

Your Excellency, President of the Republic of Mozambique,
Honourable ministers of health of Member States of the WHO African Region,
Director-General of WHO,
Madam Commissioner for Social Affairs of the African Union,
Excellencies, members of the diplomatic corps in Mozambique,
Distinguished guests and participants,
Ladies and gentlemen,

Welcome

It is with some emotion that I take the floor on this occasion to address the Regional Committee, for the first time, in my capacity as Regional Director. Once again, I wish to express my gratitude to all Member States of the WHO African Region for the confidence and opportunity given to me to serve Africa in this capacity.

It is also a privilege for me to have this opportunity to express some thoughts about the most critical health problems in the Region, to share strategies and especially to hear and learn from your experiences in this complex and continuing process of health development in the African Region.

Excellencies,
Distinguished colleagues and guests,

Permit me to express my very great appreciation of the presence, among us, of His Excellency, Mr Armando Guebuza, President of the Republic of Mozambique, who has honoured this gathering by gracing it with his presence. Mr President, I am pleased to note your commitment to improving the health of the people of Mozambique and your broader vision of development in Africa. The health policy of Mozambique clearly articulates these aspirations, and I want to assure you, Mr President, that the WHO Regional Office for Africa will spare no effort to improve its performance, in order to contribute, qualitatively and diligently, towards better health in Mozambique and indeed in the whole of Africa.

Permit me also to use the occasion to thank Your Excellency, and the Government and friendly people of Mozambique for having accepted to host the fifty-fifth session of the WHO

Regional Committee for Africa. I dare say, on behalf of WHO and participants at this forum, that the preparations Mozambique has made for this meeting have been excellent and the hospitality exemplary.

I would like, on this occasion, to pay tribute to Dr Jong-wook Lee, Director-General of WHO, for the special attention he has devoted to the African Region. I hail the honourable ministers of health of Member States, and in particular, I welcome the new ministers of health who have joined us since the last session of the Regional Committee.

Since my assumption of office as Regional Director in February this year, one of my major priorities has been to improve collaboration with the African Union. It gives me great pleasure to announce that, since I assumed office, excellent working relations have been established as part of our common development objectives and specific strategies to deal with the major health challenges in the African Region. In this regard, I would like to emphasize the presence of the Commissioner of the African Union for Social Affairs who I am convinced brings us a message to support the fundamental changes required in our health systems.

I also commend our health development partners for having honoured us here with their presence.

Health challenges in Africa

Excellencies,
Ladies and gentlemen,

Sub-Saharan Africa continues to bear the highest burden of disease worldwide. We are all aware of the persistence of diseases such as AIDS, malaria and tuberculosis; the outbreaks of epidemics such as haemorrhagic fevers and cholera; the weak protection of maternal and child health; and the increasing burden of noncommunicable diseases like cancers, diabetes, cardiovascular diseases and sickle-cell disease.

The national health policies of countries of the African Region recognize health as a right of every citizen and they seek to guarantee universal access to essential health care. These policies are consistent with the United Nations Millennium Declaration.

Notwithstanding, the health systems are facing problems of performance, mainly resulting from shortcomings in the availability and management of human, financial and technological resources. For health systems to meet the needs of the populations and achieve the health objectives in Africa, there is need for substantial investment in capacity building, especially in terms of infrastructure and human capital. In this regard, I urge ministers of

health to strengthen their leadership in the context of macroeconomic reforms in countries. I urge ministers of health to take greater advantage of the mechanisms of regional economic integration and the increasingly positive trends in official development assistance (ODA).

The main health indicators in our Region are extremely worrying, and they speak for themselves. The health profile of sub-Saharan Africa reflects the socioeconomic development context, the lifestyles of our societies and the extent of poverty of families and individuals. It is paradoxical to note that the health situation in Africa is deteriorating while humankind is making unprecedented technical and scientific progress in medicine. This very fact should make us fully appreciate the vital importance of health determinants which go well beyond the health sector. They include peace, stability, economic development, education, employment, housing, and safe drinking water which should be made accessible to all. However, the conditions of extreme poverty under which the majority of the people are living do not enable them to have access to essential health care nor to lead a decent life. Hence the need to strengthen health sector participation in the fight against poverty.

Permit me to devote a little time to addressing a public health problem that is causing us very deep concern. I mean the trend of increasing incidence of infection by the human immunodeficiency virus in the African Region where an estimated 3.2 million new infections were recorded in 2003 alone.

AIDS is causing so many deaths in sub-Saharan Africa. It claimed nearly 2.3 million lives in 2003 alone. AIDS contributes to the reduction of life expectancy at birth, which is now estimated at 47 years on average. AIDS is affecting the most productive age group of the populations. It is undermining economic growth and social stability.

In general, the number of new infections by HIV continues to increase, each year, especially among youths and more particularly among the female population. And we all know that no cure has been found as yet for AIDS. Although the increase in coverage of antiretroviral drugs is a positive development, it still falls far short of the requirements in terms of access for all those who need them.

The point I want to drive home is that the AIDS situation in our countries is very serious indeed. The general trend at present is that the epidemic is spreading. AIDS requires an exceptional, multi-dimensional response. That is why we commend the various ongoing partnerships and initiatives in AIDS prevention and control. I am therefore appealing to Member States, the populations and health development partners to redouble their efforts in the area of prevention. In this regard, I wish to inform you of my intention to propose to the fifty-fifth session of the WHO Regional Committee for Africa that the year 2006 be devoted

especially to accelerating the prevention of AIDS. We shall declare and wage a resolute battle against HIV, from all angles!

There is a widening gap between the resources Africa needs for AIDS prevention and control and the resources that are actually available. We urgently need additional financial and human resources, especially more resources for strong social mobilization and direct community involvement in health promotion and disease prevention. In order to renew and implement the AIDS prevention strategy, we will work in close collaboration with UNAIDS, UNICEF and other partners, to support governments.

Opportunities

Excellencies,
Ladies and gentlemen,

In spite of all the aforementioned challenges, the current environment of change provides us with very good opportunities to face up to the challenges.

First, world leaders, African political leaders and governments are more and more sensitive to health problems in their development concerns and plans. This is evidenced by the internationally agreed health development goals, including those contained in the United Nations Millennium Declaration; the health decisions of the various Summits of Heads of Member States of the African Union; and the health component of the New Partnership for Africa's Development.

Second, the technologies and methods required to manage the most critical health problems are available although not necessarily accessible to all those who need them. While we admit that those technologies and methods are costly, it is nonetheless true that they are within our reach through more efficient management of resources and greater international solidarity.

Third, the global environment of change and the good intentions expressed, while not being a guarantee, nonetheless provide opportunities for health systems reform at national and international levels. We should not stop at lamenting the lack of resources without doing our utmost to manage very well the little that we have.

The way forward

Excellencies,
Ladies and gentlemen,

The present situation calls for change and we should be ambitious at this decisive moment. I mean our actions must be tailored to our needs. We should explore new horizons and avenues; build new consensus; establish and strengthen alliances to address health challenges more efficiently; and better coordinate our support for national health systems by strengthening the operational capacity of ministries of health so that they can respond better to the expectations of their populations. Collective action is a must if we want to increase our efficiency and effectiveness. One of the major strategic objectives will be to ensure that ministries of health and national health services are stable and strong enough to address the numerous health challenges that they face.

As part of the efforts to achieve the internationally agreed development goals, including those contained in the United Nations Millennium Declaration, the WHO African Region will pursue a strategy comprised of five priority actions which are:

- To strengthen WHO country offices through reform of the structures and the internal culture of the Regional Office in order to make WHO more useful to Member States;
- To improve and expand health partnerships;
- To provide support for the planning and management of district health systems;
- To promote and intensify essential health interventions related to priority health problems;
- To raise awareness of, and strengthen response to, the main determinants of health status.

Excellencies,
Distinguished participants and guests,

To conclude, I wish to reiterate my optimism despite the numerous health challenges in Africa. I stand convinced that with increased dialogue, harnessed energies of the various actors, focused efforts on a limited number of priorities, and increased availability of resources, we will surely come closer and closer to achieving our health goals.

I thank you for your kind attention.

ANNEX 11

ADDRESS BY DR JONG-WOOK LEE DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION

Your excellencies,
Armando Guebuza, President of the Republic of Mozambique,
Alpha Oumar Konare, Chairman of the African Union Commission,
Mr Chairman,
Honourable ministers,
Distinguished representatives,
Colleagues,

What a spectacular welcome you have given us all. Thank you.

Africa is the centre of attention in current global discussions about the future of our world. It brings together some of our deepest concerns as well as some of our greatest hopes. People's lives depend on you, the decision-makers. This meeting, with all its ceremony, may seem far from the raw truth of poverty and disease faced by millions in Africa. It is not. The poor and the sick must be in our minds in all our discussions this week.

WHO has allocated Africa nearly 30% of all our combined income for the next biennium. This is the largest proportion of the Organization's budget. Using these resources effectively to achieve the required results will mean streamlining. It also means strong management, transparency and accountability.

Mozambique today sets a fine example. There is a saying, "Smooth seas do not make skilful sailors". The Government of Mozambique has shown its navigation abilities. It moved from 16 destructive years of war to peace in 1992. It has achieved national reconstruction with good governance, increased transparency and cooperation. Bilateral donor support has followed. The health of the country has benefited and good progress is being made towards several of the millennium development targets. Rapid declines in infant mortality and under-five deaths, especially among rural children, combined with increasing measles immunization coverage and a remarkable decrease in maternal mortality between 1997 and 2003, give us a picture of greatly increased survival for mothers and children. However, there is still much to be achieved in control of malaria, and HIV prevalence continues to climb.

Such navigation skills will be needed across the continent in the years ahead. Our common vision for the next decade recognizes that health is influenced by a wide range of

non-medical factors like poverty, deprivation and ignorance. Social, environmental, economic and political issues, such as intellectual property rights and trade agreements play a part in health outcomes. Their consequences are clear in the accumulating burden of chronic disease and the continuing death toll from infectious diseases like HIV/AIDS, tuberculosis and malaria.

We in this room are responsible for making sure that people stop dying from these diseases. However, the question of how to apportion responsibility for reducing or stopping their causes is a complex one. Your discussion later on the draft General Programme of Work will make an important contribution to this.

Two years ago I talked to this Regional Committee about getting 3 million people onto antiretroviral treatment (ART) by the end of 2005 as a first step towards universal access. Many people thought that "3 by 5" was too ambitious. Good. We *should* set aggressive targets. But it *was* a lot to achieve in the timeframe, and it is evident that reaching 3 million people will take a little longer than originally anticipated.

You have achieved much in a short space of time. Close to 1.5 million people will be on antiretroviral treatment by the end of 2005 (and most of them will be in sub-Saharan Africa). Based on this progress, universal access is now recognized worldwide as a moral and social imperative, and as a practical necessity. The commitment made by Member States to increase access to treatment has become a movement which cannot be turned back. The momentum you have created inevitably led to the G8 recently setting an even more ambitious target. This was to get "as close as possible to universal access to treatment for all those who need it by 2010". You have helped to make this possible. Access for everyone to the health care they need is now recognized as not only absolutely necessary but entirely feasible.

Overall, antiretroviral drug prices are falling as more products become available and the market expands. WHO already prequalifies 63 antiretroviral drugs, including 29 generic formulations. The recent confidentiality agreement between WHO and the US Food and Drug Administration will further support the prequalification programme, accelerating the availability of lower-priced generic antiretroviral medication.

By making treatment more widely available, more people are now motivated to come forward for testing. In one district in Uganda, introduction of ART led to a 27-fold increase in demand for HIV testing and counselling. This is a vital step. In Africa, less than 5% of people living with HIV/AIDS are aware of their status. The availability of testing and counselling must be expanded. Treatment and prevention go hand in hand, each supporting the other's ability to save lives.

However, demand is greater than people or systems can manage to supply. At least 4 million people in sub-Saharan Africa alone need this therapy. The numbers under treatment are growing. There has been a threefold increase in the number of African people currently receiving life-saving drugs in the last 12 months, but there is still much further to go with this. There is an urgent need to train health workers and address the implementation bottlenecks.

But it is a battle against time. Life expectancy is decreasing in sub-Saharan Africa. For example, in Botswana, it is currently 36.4 years. Yet it is forecast to get even worse, falling to 34.4 years of life by 2010. In Swaziland it will reach 30.6 years over the next five years. These are unfolding catastrophes. We must reverse this trend by turning back the tide of deaths from HIV/AIDS.

Universal access is also a key to tuberculosis control. Following the declaration of a global emergency in 1993, there has been a rapid scale up of DOTS across the world, and the incidence of TB is either declining or stable in most of the world. Only in Africa is the rate still increasing rapidly, resulting in a net global increase in incidence of about 1% a year. In Africa, incidence rose to 345 cases per 100 000 population in 2003 and mortality is by far the highest in the world. TB is a massive public health concern both for Africa and for the world. Transmission and development of drug resistance are accelerated by the HIV epidemic. The control activities for these two diseases need to be very closely coordinated. Some 35% of African TB cases are HIV infected, compared to about 8% for the world as a whole. We have effective and available treatments for both. We have a cure for TB. The main obstacles to implementing these treatments and stopping needless deaths are the same; the health systems are not yet strong enough, and there are not enough trained health workers.

Over the years of the polio eradication effort, we have together made progress towards almost universal vaccine coverage in polio-endemic countries. However, the reintroduction of the virus to several previously polio-free countries has also demonstrated how easily we can lose the fragile advantages we have gained for health.

Only when immunization has reached every single child will the transmission of poliovirus be stopped. The African Union responded to the outbreaks last year with synchronized polio campaigns in 24 countries that reached about 100 million children. This is the largest ever internationally coordinated operation to have been carried out in peacetime. Thanks to your support, presidents and prime ministers participated in the launch of this effort and renewed their commitment to stopping polio in Africa. As a result, this year, west and central Africa have reported the lowest level of polio cases in recent years.

We need to increase the polio immunization campaigns in the Horn of Africa and in Nigeria, where too many children are still being missed. Immunization and full coverage with surveillance are a pressing need for all countries. The equipment, supplies and health workers being deployed to achieve this make a vital contribution to the whole health infrastructure, particularly for protection against the childhood diseases.

"Make every mother and child count" was the theme of this year's World Health Day. Here too, financial barriers to access need to be reduced and an effective workforce built.

To make this more real, let's look at the experience of one 17-year-old pregnant girl from Ethiopia. Her name is Hiwot. She and her daughter Elizabeth are included in the six-country photo essay linked to the launch of *The world health report* this year. You can also see their pictures on the WHO web site under the title "Great Expectations". This was Hiwot's first pregnancy. She was then still a schoolgirl, living with her mother and sister. When she knew she was pregnant, Hiwot walked 30 minutes to attend the nearest antenatal clinic. She's lucky to be able to do this. Only one in four Ethiopian women are able to make even one such visit. Elizabeth was born safely, with the assistance of Doctor Asfau, and weighed 3.3 kg. Fortunately there were no complications as the hospital had no special help, and only limited facilities. There was no running water, only a bucket. In Hiwot's country, only 9.7% of births are assisted by a skilled attendant and one in 14 women dies in pregnancy or childbirth. Baby Elizabeth has grown well, being breastfed, and made it safely past her seventh day of life. But 38 out of every 1000 babies die in their first week. She has made a start on the immunizations she needs to protect her. One in six Ethiopian children dies before their fifth birthday from preventable diseases such as pneumonia, diarrhoea and malaria.

These are the figures that we have to change. But they are not just figures. They are people's lives. All the Elizabeths and Hiwots of this world must have the best possible chance of health, equally.

For malaria, the Abuja Declaration set 2005 as the year in which coverage rates should reach 60% for the main curative and preventive interventions. Few countries will reach that target this year. The supply crisis for artemisinin-based treatments is one of the reasons for the delay. Large-scale cultivation of *Artemisia annua* in eastern Africa could provide a reliable and adequate supply. We are also looking at ways to make long-lasting insecticide-treated nets available to 80% of young children and pregnant women before 2010. Globally, local manufacture of these products, and of essential medicines such as antiretrovirals and antimalarials, move countries further towards self-reliance and increased national capacity. Domestic production brings strengthened regulatory systems and reduced dependence on external financing.

Despite the progress being made in access and coverage, significant challenges to health systems still remain. Behind every area of vulnerability in health systems nationally and globally is the lack of health care workers. Without enough skilled workers, health care systems cannot function properly. Vital programmes cannot be carried out. Daily directly-observed treatment for TB just can't be done if the only health worker is 25 miles away. The annual review of the Stop TB Programme found that ten of the 22 high-burden countries reported major deficiencies in staffing at central level and another seven were struggling for staff at peripheral level. A study by the Global Alliance on Vaccines and Immunization (2003) found that management and human resources represent a major constraint in 40 vaccine-fund-eligible countries and in 18 was the primary barrier to scaling-up immunization. Reviews of the implementation of Integrated Management of Childhood Illness noted human resource barriers as critical health system constraints. A major investment is needed to expand and retain the health workforce in Africa as a whole by the recommended one million workers by 2010.

Next year we will launch the world health report on the human resources crisis. Through your efforts the problems of migration have been brought to world attention. The two recently-adopted World Health Assembly resolutions on the international migration of health personnel were initially sponsored by African nations. These must now be implemented.

The adoption of the International Health Regulations (2005) by the World Health Assembly this year was a historic step. Pandemic influenza was a dominant concern of the negotiations, and it is a danger that has continued to increase. Marburg fever in Angola, with its high fatality rate, appears to be controlled, but it was a particularly harsh reminder of the hazards we face. It also demonstrated how coordinated, rapid and effective action could gain control of outbreaks faster.

At present the need for security measures against pandemic influenza outbreaks is felt largely in Asia and the Pacific. But no country can afford to ignore this risk. Such a pandemic can affect all countries equally in the space of a few days. Avian influenza is not formally on the agenda for this Regional Committee, but Africa's peoples are as vulnerable to infection as anyone else. No effort must be spared to build the necessary mechanisms for disease detection, alert, response and information-sharing, both within countries and between them.

Despite the many challenges for controlling infectious diseases, we cannot afford to ignore the rapidly growing burden of chronic diseases in Africa. Total deaths in Africa from noncommunicable diseases are projected to increase by 27% over the next ten years. Most notably, diabetes mellitus mortality is projected to increase by 42% between now and 2015. Cardiovascular diseases are now the leading cause of death worldwide. By 2015, they will

still be the leading cause of chronic disease mortality, accounting for 46% of all deaths from this cause in Africa. I welcome the Regional Committee's discussion of this important topic and urge you to take immediate preventive action. The global report on preventing chronic disease, coming out in October, will stress the importance of taking steps now, in all developing countries, to curb the rise of cancer, cardiovascular disease, chronic respiratory disease and diabetes, among others. I thank those of you whose countries have become parties to the Framework Convention on Tobacco Control, and urge the rest of you to follow suit. It is an excellent example of how international cooperation can provide strong support for national efforts to tackle the root causes of cancer and heart disease.

Slow progress in reducing poverty and ill-health is widely recognized as a grave danger to security and development. Yet, the delayed response in the international community to repeated government and United Nations appeals for aid to countries in the Sahel (Mali, Mauritania, Niger) is in strong contrast to the millennium commitments made. WHO played its part in a timely manner in Niger: there has been very good cooperation between the Ministry of Health, WHO and other humanitarian partners to get the relief efforts off the ground.

Again, let's look at a personal example. Aminatou Iyaye from Niger has a field of chickpeas in which nothing is growing. The locusts ate everything last year. Her village eats once a day, if they are lucky. Their food is maize flour mixed with water and a little sugar. The water is untreated, and comes from an open well. There is a threat of cholera. Her daughter, Oumana, is in a precarious situation. She is four months old and severely malnourished, weighing less than 2kg, half of what Elizabeth from Ethiopia weighed at one week old. There are an estimated 32 000 severely malnourished children like Oumana in Niger. Experts have been working with Ministry of Health officials to avert the crises in nutrition and outbreaks of infectious disease, setting up emergency vaccination programmes and training volunteers to help with screening and referral of children. All of this is very positive. The people of Aminatou's village have renewed hope.

However, I am concerned that no attention was paid to the warning signals sent out by the Government of Niger and by our offices last year, until the situation reached crisis level. The Millennium Development Goals and our own global agenda will not be reached through crisis management, but by steady work on strengthening the fundamental systems and resources in countries.

There is great potential for progress. The main problems are known and recognized, and are being tackled. Moves towards debt relief and increased development assistance have begun to present a real possibility of recovery and new strength in Africa. Increased investment in health, combined with good governance, and stewardship of external and

internal resources can yield the high returns that are so urgently needed. The decisions you will be making this week can accelerate these positive trends, and bring life-saving interventions to the many people who count on your support.

What you achieve here in this continent will have an effect on the rest of the world. I wish all of us every success in the important discussions of this week. Let us use them to combine our strengths and seize the opportunities now before us to bring new strength and health to the peoples of Africa.

Thank you.

**STATEMENT BY H.E. PROF ALPHA KONARE
CHAIRMAN OF THE AFRICAN UNION COMMISSION**

(read on his behalf by the Adv. Bience Gawanas, Commissioner for Social Affairs)

Your Excellency Armando Guebuza, President of the Republic of Mozambique,
Dr Jong-wook Lee, WHO Director-General,
Dr Luis Gomes Sambo, WHO Regional Director,
Honourable ministers,
Your excellencies, members of the diplomatic corps,
Invited guests,
Representatives of the civil society,
Members of the press,
Distinguished guests,
Ladies and gentlemen,

I feel honoured to address you on behalf of His Excellency Alpha Konare, Chairperson of the African Union Commission, who was unable to join you. He requested me to convey his greetings and best wishes for a successful meeting.

I am very delighted to join distinguished delegates here in Maputo, Mozambique on the occasion of the fifty-fifth session of the WHO Regional Committee for Africa. Right at the outset, I would like to thank His Excellency Armando Guebuza and the people of Mozambique for the hospitality extended to our delegations since our arrival in this beautiful city of Maputo.

Let me also thank the Government of Mozambique for hosting this important meeting. Dr Jong-wook Lee, WHO Director-General, and Dr Luis Gomes Sambo, the WHO Regional Director for Africa, need to be commended for the excellent work they are doing in order to improve the health conditions on this continent. Of course, WHO is a long-time partner of the African Union Commission.

Our relationship dates as far back as 1969 when WHO became the first UN organization to sign a cooperation agreement with the then Organisation of African Unity which is a predecessor and a precursor of the African Union Commission. Since then our relationship

has grown from strength to strength, and in the years that followed, other UN agencies have followed suit.

Let me hasten to say that this meeting could not have come at any better time given that the UN Summit will be taking place next month where the progress towards the achievement of the Millennium Development Goals will be reviewed. As an input to this Millennium Development Goals review process, the African Union Commission has prepared an African common position at the request of heads of state and government. Preliminary indications are that Africa needs to do more if the Millennium Development Goals are to be attained.

The African Union Commission recognizes that the healthy nation is an asset to every country. It is against this background that the leadership of the African Union is committed to changing the appalling health situation in Africa. This is demonstrated in the various declarations and resolutions adopted by the heads of state and government of the African Union, the most important ones being the Abuja Declaration on Roll Back Malaria in Africa, 2000; the Abuja Declaration on HIV/AIDS, TB and other Infectious Diseases, 2001; and the Maputo Declaration on Malaria, HIV/AIDS, TB and other Infectious Diseases, 2003.

Despite this political commitment, the health status of the African population is still very low by any standard. The major determinant of poor health in Africa is the state of our health systems. There are, however, other causes that lie beyond the control of health systems and they include among other things, poverty, armed conflict, institutional instability and the state of basic infrastructure.

The AUC would, therefore, intensify its activities, aimed at promoting good governance and conflict prevention. The Commission would also be looking into ways and means of strengthening health systems in conflict and post-conflict situations, of course with the support of partners like WHO.

HIV/AIDS, malaria and tuberculosis along with other related infectious diseases continue to tear our continent apart. Access to drugs is the key in the fight against these diseases in Africa. As one way of addressing this problem, the AU Assembly in January 2005 came up with a decision aimed at promoting the production of generic drugs on the continent in order to make drugs available on a sustainable basis. Pursuant to this decision I am pleased to report to this august gathering that AUC is working with the WHO Regional Office to conduct a drug production capacity mapping exercise for Africa. The end product of this process will be the development of a Pharmaceutical Manufacturing Plan for our continent.

I wish to bring to your august attention that the apparent stabilization of the HIV/AIDS epidemic in some African countries is essentially due, unfortunately, to an increase in

mortality among the high-risk groups rather than a genuine and rapid decrease of the disease. It is a deplorable situation that requires from all leaders political, spiritual, energetic and synergistic efforts to reverse it. I therefore associate myself with the Regional Director's initiative to declare 2006 the Year of Acceleration of the Prevention of HIV/AIDS in Africa.

Let me reiterate here that the battle against HIV/AIDS will either be won or lost in Africa. It is therefore imperative that resources aimed at fighting HIV/AIDS should be heading in the direction of Africa wherever they are coming from.

In the areas of violence and health, heads of state and government of the African Union passed a resolution endorsing the recommendations of *The world report on violence and health* in 2003 and requested Member States to develop national plans of action for violence prevention and systems for data collection on violence.

The African Union resolution further requested Member States to declare 2005 the African Year of Prevention of Violence. The WHO and other partners are supporting Member States in implementing this decision, and the AU Commission, in collaboration with WHO, is now running a project on violence prevention. This is important in view of the violence related to conflicts and other causes which are prevalent on the continent.

With respect to epidemics of emerging and re-emerging diseases, outbreaks were reported and these included Marburg in Angola and ebola in Democratic Republic of Congo. Prevention and control of such epidemics require effective emergency preparedness and response systems, and strict application of the International Health Regulations. There are many challenges which are complicated by the lack of surveillance systems and the fact that there are no effective vaccines against these viruses yet. New infectious diseases continue to emerge in Africa, and I would like to express my gratitude to WHO for the support they render to the African Union when such emergencies occur. Improved performance in controlling emerging and re-emerging diseases in developing countries is dependent on the quality, equity and efficiency of health systems, and I need not emphasize the state of our health systems in Africa.

As concerns polio eradication, effective interventions are in place to interrupt further transmission through universal immunization of all children in the Member States affected by polio outbreaks. A lot of progress has been made towards eradication of polio. However, Africa needs to intensify efforts to prevent further transmission, especially in countries affected by conflicts and other emergencies. It must be pointed out here that, according to the Global Polio Eradication Initiative, the resurgence of polio in some African countries was due to misinformation and other challenges. This clearly shows that, if we are to succeed in eradicating polio, we need to keep our advocacy, education and vaccination campaigns alive

all the time. Let me take this opportunity, your excellencies, distinguished ladies and gentlemen, to commend all the heads of state of countries that participated in the first phase of the coordinated polio vaccine in west and central Africa.

The role of traditional medicine in Africa is too significant to be ignored. The AUC is now in the process of implementing the African Decade on Traditional Medicine (2001-2010) and is also reviewing the Bamako Initiative on essential drugs. This is in line with the World Health Assembly's decision on the identification of centres of excellence in Africa for the production of generic drugs, especially those for HIV/AIDS, tuberculosis and malaria.

Your excellencies, distinguished ladies and gentlemen,

You will agree with me that maternal and child health in Africa has not improved in the last decade. The risk of women dying or becoming disabled from pregnancy and childbirth in Africa remains unnecessarily high. This means that pregnancy constitutes a journey from which many women in Africa never return. Definitely this need not be the case. We need to seek redress. It is in this connection that the AU Commission is working with WHO and other partners to develop the Roadmap to Accelerate the Reduction of Maternal and Newborn Morbidity and Mortality in Africa and to write a Comprehensive Action Plan on Reproductive Health in Africa which is one of the priority lines of action of the AU Commission for 2005. With respect to access to reproductive health services, the AUC welcomes the UNFPA Reproductive Health Commodity Security Initiative.

In the area of health financing, it will be recalled that the heads of state and government of the African Union committed themselves in the Abuja Declaration to allocate 15% of their national budget to health. Progress on this commitment reveals that four countries are allocating less than 5%, 25 countries between 5% and 10% and 13 countries between 11% and 14%. I would like to urge Member States of the African Union to do all they can in order to increase resources for the health sector. This should be an integral part of the overall health systems strengthening process.

Before I conclude my remarks I would like to confirm to the honourable ministers present that the second AU Conference of Ministers of Health will be hosted by the government of Botswana in Gaborone 10-14 October 2005. The theme of the conference is "Sustainable Access to Treatment and Care for the Achievement of the Millennium Development Goals". The major issues to be discussed will include the Bamako Initiative on essential drugs, traditional medicine, WTO/TRIPS and access to drugs, local drug production in Africa, health systems strengthening and health research. I look forward to meeting all of you in Gaborone.

Finally, I would like to re-affirm the willingness and readiness of the African Union and the Commission to continue working side-by-side with the WHO in addressing the health challenges on the African continent.

I thank you.

ANNEX 13

STATEMENT BY ARMANDO EMILIO GUEBUZA PRESIDENT OF THE REPUBLIC OF MOZAMBIQUE

Honourable Minister of Health of Eritrea and Chairman of the fifty-fourth session of the WHO Regional Committee for Africa, Dr Saleh Meky;

Director-General of WHO, Dr Jong-wook Lee,

African Union Commissioner for Social Affairs, Dr Bience Gawanas,

WHO Regional Director for Africa, Dr Luis Gomes Sambo,

Honourable Minister of Health of Mozambique, Dr Paulo Ivo Garrido,

Members of the Council of Ministers,

Members of the diplomatic corps,

Dear delegates,

Distinguished guests,

Ladies and gentlemen,

Permit me, first and foremost, to welcome the delegates to the fifty-fifth session of the WHO Regional Committee for Africa in this city of acacias and jacarandas, the beautiful capital of Mozambique, located on the bay of Maputo, from which the city derives its name. We wish to express our satisfaction and pride that Mozambique has been chosen to host this important meeting which will discuss various topics related to combating diseases and improving the health care provided to our citizens.

We would like to take this opportunity to express our deep appreciation of the presence at this gathering of dignitaries from many parts of the world. We also appreciate the fact that you have put this meeting high on your agenda which underscores the importance that you attach to the search for appropriate solutions in promoting the well-being of our people and our countries. We welcome the presence at this gathering of health officials from all the provinces of Mozambique and of distinguished representatives of civil society in this country.

To Dr Luis Gomes Sambo, we reiterate our congratulations on his election as WHO Regional Director for Africa. Our expectation is that he will lead his team to revitalize actions to improve the health conditions of the populations of our continent.

During your stay in this beautiful city, ladies and gentlemen, we would like you to feel at home. Take advantage of the beautiful scenery and tourist attractions that our country

offers. Above all, enjoy the hospitality and friendliness offered you. Do not let pass an opportunity to return the smiles of our hospitable people, because, here in Mozambique, a smile is a renewable resource. Enjoy also our art and culture and, especially, our cooking.

Ladies and gentlemen,
Distinguished delegates,

The Republic of Mozambique has been a member of the World Health Organization since 11 September 1975, the year of our independence. In 1979, we hosted, for the first time, the annual session of the WHO Regional Committee for Africa during which important decisions were taken on how best to increase access to health care and improve health status in the Region.

Today, we are deeply honoured to host the annual meeting of the WHO Regional Committee for Africa for the second time. This meeting has special importance in a new national and international context. The meeting's agenda emphasizes the importance of combating communicable diseases affecting our people. Furthermore, it reflects the improvement of the health status of our people.

It is well known that the prevalence of communicable diseases as well as maternal and child mortality are high in the African Region, resulting in a decrease in average life expectancy. HIV/AIDS is one of the worst public health scourges. Its related morbidity and mortality adversely affect economic performance of the countries in this Region. This situation is compounded by the weaknesses and fragility of the health systems as well as the inadequacy and poor management of human, financial and technological resources.

The magnitude of the problems facing our countries goes far beyond their capacity to address and resolve them with their own resources alone. The developed countries have a responsibility to increase official development assistance to the poor countries. Furthermore, foreign debt cancellation, greater access to markets, transfer of technologies and increase of direct foreign investment are equally important factors.

Ladies and gentlemen, the health status and the epidemiological profile of the people of Mozambique are, to a large extent, the result of the current level of socioeconomic development. The burden of endemic diseases is high. Examples are malaria and diarrhoea which, together with malnutrition, affect primarily children aged below five years. HIV/AIDS is more prevalent among women, and this trend is constantly growing. The increase in the incidence of mother-to-child transmission of HIV continues to be a concern.

We are particularly encouraged to note that the theme of *The world health report 2005* is "Make every mother and child count". We understand that women's health is a tool of emancipation of women, just like education and vocational training. We believe that, if properly articulated, women's health can significantly improve women's visibility among the actors that produce national wealth.

In Mozambique's five-year health sector programme, women and children are the focus of our concern. In this respect, the country is planning activities that will help improve access to education, employment and free health care for pregnant women and for children below five years of age. We also give priority to reducing the incidence and prevalence of vaccine-preventable diseases among children aged up to 23 months, school-going children and women of child-bearing age. Currently, the national immunization campaign is under way, and the level of coverage already achieved is encouraging. At the same time, efforts are being made to improve the nutrition status of the population and to increase access to maternal health, especially in rural areas.

Distinguished delegates, this meeting is taking place at a time when the world is preparing to make the first evaluation of the progress made in the implementation of the Millennium Development Goals since their adoption in 2000. Under these goals, the following have been set as health priorities up to 2015:

- reducing child mortality;
- improving maternal health;
- combating HIV/AIDS, malaria and other diseases.

For us, Africans, this should be a moment of brainstorming on how best to improve our participation in this drive to achieve the Millennium Development Goals.

We hope that your discussions will take into account the role of the World Health Organization and each of the countries in implementing activities for prevention, treatment, research, mitigation and advocacy with regard to diseases and their effects, with a view to improving the socioeconomic conditions of our people. Convinced that we shall achieve the basic values indispensable for human dignity, we, once again, wish you a pleasant stay and success in your deliberations.

On this note, we have the honour to declare officially open the fifty-fifth session of the Regional Committee for Africa.

Thank you.

**PROVISIONAL AGENDA OF THE FIFTY-SIXTH SESSION OF
THE REGIONAL COMMITTEE**

1. Opening of the meeting
2. Constitution of the Subcommittee on Nominations
3. Election of the Chairman, the Vice-Chairman and the Rapporteurs
4. Adoption of the Agenda
5. Appointment of members of the Subcommittee on Credentials
6. The Work of WHO in the African Region 2004-2005: Biennial Report of the Regional Director:
 - 6.1 Progress in implementation of the 2004-2005 Programme Budget in the African Region
 - 6.2 Progress reports on specific resolutions:
 - (a) Adolescent health: A strategy for the African Region
 - (b) Women's health: A strategy for the African Region
 - (c) Addressing the resurgence of wild poliovirus transmission in the African Region
 - (d) Child sexual abuse: A silent health emergency
 - (e) Improving access to care and treatment for HIV/AIDS in the African Region: The 3 by 5 Initiative and beyond
 - (f) Occupational health and safety in the African Region: Situation analysis and perspectives
 - (g) Priority interventions for strengthening national health information systems
 - (h) Repositioning family planning in reproductive health services: Framework for accelerated action, 2005-2014
 - (i) Microeconomics and health: The way forward in the African Region
 - (j) Strengthening the role of hospitals in national health systems in the African Region
 - (k) Scaling up interventions against HIV/AIDS, tuberculosis and malaria in the African Region
 - (l) Regional strategy for immunization during the period 2003-2005
 - (m) Human resources development for health: Accelerating implementation of the regional strategy

7. Correlation between the work of the Regional Committee, the Executive Board and the World Health Assembly
 - 7.1 Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
 - 7.2 Agendas of the one-hundred-and-nineteenth session of the Executive Board, the Sixtieth World Health Assembly and the fifty-seventh session of the Regional Committee
 - 7.3 Method of work and duration of the World Health Assembly
8. Report of the Programme Subcommittee
 - 8.1 Regional Strategic Plan for Expanded Programme on Immunization 2006 –2009
 - 8.2 HIV/AIDS prevention in the African Region: A strategy for renewal and acceleration
 - 8.3 Onchocerciasis: Emerging issues and challenges
 - 8.4 Trade and health: An emerging health development issue
 - 8.5 Health financing: A strategy for the African Region
 - 8.6 Drug regulatory authorities, vaccines and narcotics control: A matter of concern
 - 8.7 Revitalizing health systems in the context of primary health care within the African Region
 - 8.8 Child survival: A strategy for the African Region
9. Information
 - 9.1 Polio eradication in the African Region: Progress report
 - 9.2 Leprosy elimination: Progress report
 - 9.3 Implementation of International Health Regulations
10. Round Table: Intersectoral action for health promotion and disease prevention
11. Panel Discussion: Malaria control in the African Region: Experiences and perspectives
12. Reports of the Round Table and Panel Discussion
13. Dates and places of the fifty-seventh and fifty-eighth sessions of the Regional Committee
14. Procedural decisions
15. Adoption of the report of the Regional Committee
16. Closure of the fifty-sixth session of the Regional Committee.

LIST OF DOCUMENTS

AFR/RC55/1	Adoption of the Agenda
AFR/RC55/1 Add. 1	Programme of work of the Regional Committee
AFR/RC55/2	The Work of WHO in the African Region 2004: Annual Report of the Regional Director
AFR/RC55/3	Ways and means of implementing resolutions of regional interest adopted by the World Health Assembly and the Executive Board
AFR/RC55/4	Agendas of the one-hundred-and-seventeenth session of the Executive Board, the Fifty-ninth World Health Assembly and the fifty-sixth session of the Regional Committee
AFR/RC55/5	Method of work and duration of the World Health Assembly
AFR/RC55/6	Report of the Programme Subcommittee
AFR/RC55/7	WHO Programme Budget 2006-2007: Orientations for implementation in the African Region
AFR/RC55/8	Country cooperation strategies: Implementation, lessons learnt and the way forward in the African Region
AFR/RC55/9	Achieving the health Millennium Development Goals: Situation analysis and perspectives in the African Region
AFR/RC55/10	Local production of essential medicines, including antiretrovirals: Issues, challenges and perspectives in the African Region
AFR/RC55/11	Control of human African trypanosomiasis: A strategy for the African Region
AFR/RC55/12	Cardiovascular diseases in the African Region: Current situation and perspectives
AFR/RC55/13	Implementation of the Framework Convention on Tobacco Control in the African Region: Current status and the way forward
AFR/RC55/14	Reproductive cloning of human beings: Current situation
AFR/RC55/15	Guiding principles for strategic resource allocations
AFR/RC55/16	General Programme of Work 2006-2015
AFR/RC55/RT/1	Prevention of HIV/AIDS in the African Region

AFR/RC55/PD/1	Social determinants of health and health inequalities: A matter of concern in the African Region
AFR/RC55/17	Dates and places of the fifty-sixth and fifty-seventh sessions of the Regional Committee
AFR/RC55/18	Procedural Decisions
AFR/RC55/19	List of Participants
AFR/RC55/20	Report of the Regional Committee
Decision 1	Composition of the Subcommittee on Nominations
Decision 2	Election of the Chairman, the Vice-Chairmen and the Rapporteurs
Decision 3	Appointment of members of the Subcommittee on Credentials
Decision 4	Credentials
Decision 5	Replacement of members of the Programme Subcommittee
Decision 6	Provisional agenda of the fifty-sixth session of the Regional Committee
Decision 7	Agenda of the one-hundred-and-seventeenth session of the Executive Board
Decision 8	Method of work and duration of the Fifty-ninth World Health Assembly
Decision 9	Ministerial Summit on Health Research 2008
Decision 10	Dates and places of the fifty-sixth and fifty-seventh sessions of the Regional Committee
Decision 11	Nomination of representatives of the African Region on the Roll Back Malaria Partnership Board
AFR/RC55/R1	WHO Programme Budget 2006-2007: Orientations for implementation in the African Region
AFR/RC55/R2	Achieving the health Millennium Development Goals: Situation analysis and perspectives in the African Region
AFR/RC55/R3	Control of human African trypanosomiasis: A strategy for the African Region
AFR/RC55/R4	Cardiovascular diseases in the African Region: Current situation and perspectives
AFR/RC55/R5	Tuberculosis control: The situation in the African Region

AFR/RC55/R6	Acceleration of HIV prevention efforts in the African Region
AFR/RC55/R7	Vote of thanks
AFR/RC55/INF.DOC/1	Report on human resources in WHO in the African Region
AFR/RC55/INF.DOC/2	International migration of health personnel: A challenge for health systems in developing countries
AFR/RC55/INF.DOC/3	Tuberculosis control: The situation in the African Region
AFR/RC55/INF.DOC/4	Sickle-cell disease: A public health problem in the African Region
AFR/RC55/INF.DOC/5	Avian influenza: Spread and pandemic preparedness and response in the African Region
AFR/RC55/INF.DOC/6	Smallpox: Destruction of variola virus stocks
AFR/RC55/Conf.Doc.1	Speech by Prof Paulo Ivo Garrido, Minister of Health, Mozambique
AFR/RC55/Conf.Doc.2	Speech by Dr Saleh Meky, Minister of Health, Eritrea, Chairman of the fifty-fourth session of the WHO Regional Committee for Africa
AFR/RC55/Conf.Doc.3	Speech by Dr Luis Gomes Sambo, WHO Regional Director for Africa
AFR/RC55/Conf.Doc.4	Address by Dr Jong-wook Lee, Director-General of the World Health Organization
AFR/RC55/Conf.Doc.5	Statement by H.E. Prof Alpha Konare, Chairperson of the African Union Commission
AFR/RC55/Conf.Doc.6	Statement by Armando Emilio Guebuza, President of the Republic of Mozambique
AFR/RC55/INF/01	Information Bulletin for Republic of Mozambique